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AN UNUSUAL CASE OF LATE SYPHILIS OF THE TESTICLE.

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Gumma is a late manifestation of syphilis and rarely appears before the fourth year of the disease. However, there is great variability as to the time of occurrence in different cases. Fournier reported a case in which the gumma appeared fifty-five years after the primary sore. On the other hand there are cases in which the gumma is so precocious as to appear during the first year of the disease.

Gummata are very slow of evolution and may terminate either by resolution or ulceration and repair. In the latter process the centre of the tumor becomes soft and fluctuating and the overlying skin then becomes inflamed and adherent, afterwards the skin ulcerates and the softened contents of the gumma discharges and it heals by granulation. The course of this ulcer may be modified by the occurrence of gangrene, phagedenism, or an aggravated inflammation. Virchow considers that late syphilis of the testicle manifests itself by two distinct pathological conditions. "First, sclerosis of the connective tissue; secondly, gummatous formations. In the first of these processes the organ is moderately enlarged, it is not tender and causes little inconvenience—sometimes so little as not to attract the attention of a phlegmatic person. There is often a hydrocele accompanying this condition which is quite noticeable. As time progresses in an attack of this nature the testicle, which was moderately enlarged, gradually begins to contract. This increasing pressure finally destroys the parenchyma of the organ, and atrophy results."

"In the second process there is gummatous formation. Here at

an early stage the enlargement of the testicle is greater than in the first variety, the size of a goose's egg frequently being attained. The organ is hard and dense to the feel. It is not tender and, in fact, the ordinary testicular feel is wanting. Commonly the contour of the testicle is regular, though at times it may be nodular, in which instances there usually exist multiple gummatous foci. If now the process is allowed to progress undisturbed, it will be found that over a certain area the scrotal tissues become more and more adherent to the testicle. Then over this area the surface of the scrotum at length presents a red, glazed appearance. If it be palpated over the center of this red, glazed surface a sensation of softening and perhaps fluctuation will be gotten. Shortly after this area begins to bulge out. Distinct fluctuation can now be detected, although there is no heat, pain nor tenderness. As a next step the tissues in the middle of this area break down, giving exit to an abundant glary gummatous material. After the destructive force of the gumma expends itself Nature attempts repair. Granulations spring up, but at the same time a contraction sets in in connection with the firm capsule of the testicle and as the contents of the organ can offer no resistance owing to the opening left by the gumma more or less of the parenchyma is crowded out at the opening, covered by the granulations which line the cavity. This condition constitutes the benign fungus. One does not see this state of affairs very often now, at least in parts of the world adjacent to medical centers since the process of destruction, leading up to this condition is so well known that the patient is put on syphilitic treatment and the gumma avoided." In White and Martin's Genito Urinary Diseases we find the following on Fungus or Hernia of the Testicle: "There are two varieties: (1) true or glandular fungus made up of a mass of granulation tissue, which sometimes contains seminiferous tubules growing from within the tunica albuginea; (2) false or parietal fungus, consisting of exuberant granulations springing from the tissues of the scrotum or from the surface of the tunica albuginea. Fungus of the testicle may be caused by suppuration, gangrene, syphilis or tuberculosis." Reclus states that hernia of the testis implies protrusion of the gland still covered with its fibrous envelope through an opening in the scrotum. The case I wish to report is of a man 41 years old, who contracted syphilis in January, 1897. He was put on pills of Protoiodide of mercury, which he took for three months. An eruption appeared on his body six weeks after the primary sore. After three months treatment of protoiodide of mercury he was put on the "mixed treatment," consisting of Bichloride of mercury and Iodide of Potash, this was kept up for nine months, making in all twelve months that he took medicine. At this time all symptoms had disappeared and he discontinued the treatment.

In one year from the time he stopped taking medicine evidences of the disease reappeared in the form of syphilitic rupia on left leg and by a swelling of left testicle, which attained the size of a goose's egg. He now commenced taking a patent remedy which is loudly heralded over the country as a cure for syphilis and all blood troubles. This remedy is called "S. S. S.," and if the condition he got in while taking it could be sent out as an advertisement, I doubt that another bottle of it could ever be sold.

During the year in which he took this remedy his testicles kept on enlarging, his legs ulcerated and a syphilitic rupia appeared on arm and chest. Finally about June, 1900, the scrotum at lower end of left testicle became glazed and red and an ulcer appeared. The ulcerative process continued and in August, 1900, the testicle came through the opening in the scrotum. I could get no history of an accompanying hydrocele and patient said there had never been any pain in testicle except some uneasiness in the cord, due to the increased weight of organ. I could get no history of softening or fluctuation at point where testicle came through nor was there the usual abundant discharge coincident with the rupture of a disintegrated gumma of testicle. I first saw this patient on the 2nd of October, 1900, when his testicle was in the condition pictured in plate one. The intimate coverings of the testicle

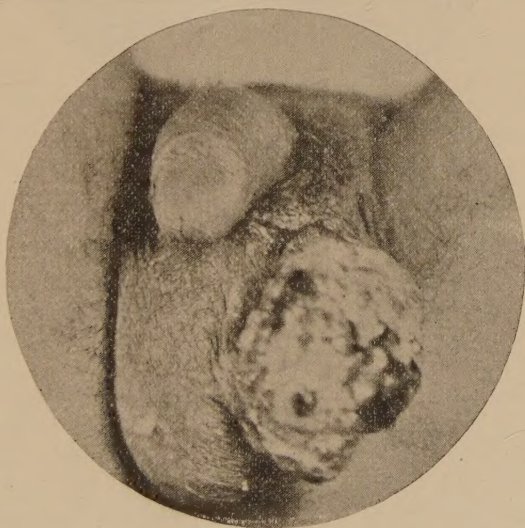


PLATE 1.

were sloughing and it was the foulest smelling condition I ever encountered. The amount of protrusion of the testicle is not very well

shown in plate one as it was taken directly from the front, but the whole testicle was outside the scrotum and the ulcer edges of the latter somewhat indurated and thickened. As a rule all syphilitic conditions are amenable to syphilitic treatment, but after dressing this case for several days I decided there was nothing to do but remove the testicle. I operated on October 5, and the condition after operation is shown in plate two, with drainage tube in lower angle of wound. Patient was

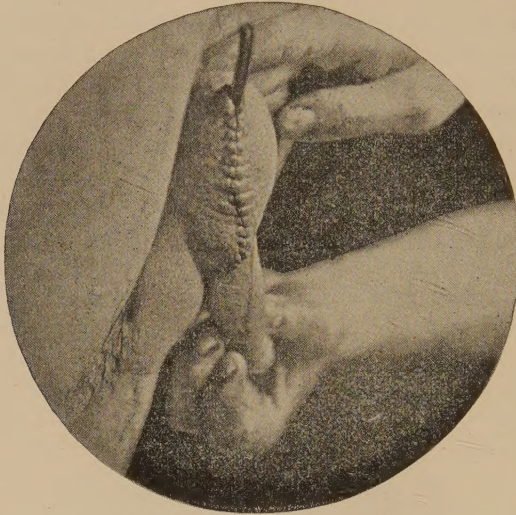


PLATE 2.

at once put on increasing doses of Iodide of Potash and had a teaspoonful of mercurial ointment rubbed into him every day. The scrotum united by first intention, but afterwards one of the silk ligatures caused trouble and had to be removed. After this all healed in a few days. He bears the Iodide of Potash and mercury well and commenced improving in a few days after it was started.

I ran the dose of Iodide of Potash up to 180 grains daily when he commenced to complain of frontal headache. He is now taking 75 grains per day. The ulcers of leg have healed nicely and he feels as well as he ever did. This is an unusual case as hernia testis is rarely seen, and especially due to late syphilis. The usual course of syphilitic gumma of this organ is an excavation in testicle which fills up by granulation. There was probably an element of gangrene in this case which uncovered the testicle sufficiently to release it from within the scrotum.

VITAL QUESTIONS IN MEDICINE.*

By T. A. CASEY, M. D.,

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It has been said that this was a day of bacteriology, and indeed, the statement would have been true fifteen years ago and I feel sure that the facts would warrant the conclusion that the study of micro-organisms is the most important and the discoveries in this field are the most brilliant and most promising than any other line of investigation in the whole medical science since Jenner's day. Jenner's discovery of vaccination was far in advance of the profession and I might say the civilized world in his day. The same may truthfully be said of Koch for it has now been almost twenty years since he discovered the cause of that arch enemy to the human race, viz.: tuberculosis and today there are a great many people, and I am sorry to say, some among our own profession who do not fully realize the importance of this great discovery.

Every well informed physician knows that Jenner's theory of protecting the people against smallpox met with fierce and obstinate opposition, but it has stood the test of over a century and its uniform success has carried conviction to all intelligent minds where there has been time and pains spent to investigate the subject. It has now, I am glad to say, become a matter of common intelligence as to whether a person believes in vaccination or not. In the 17th century the practice of inoculation was introduced into Europe by Lady Mary Wortley Montagu. A letter written by her attracted wide attention and in this letter she says that she would lay the matter before some of the physicians, but she did not think that they would be willing to destroy such a considerable amount of their revenue for the good of mankind. Little did she think that a Jenner would rise up from the medical profession and give to the world and mankind a system far superior to hers. The practice of inoculation had a great many things to commend it in its day, but it was a means of spreading the disease and occasionally a death would occur from its use, so it was made a violation of law in some parts of the world. On the other hand, vaccination is so harmless and so uniformly successful that it has been made compulsory by law in a great many civilized countries. The chief point that distinguishes us as true physicians from boastful pretenders and quacks is the fact that we give all of our discoveries to the world at large for the good of mankind, while the quacks will resort to secret remedies on account of pecuniary interests.

Bacteriology has pointed out with certainty the cause of tuberculosis, bubonic plague, diphtheria, typhoid fever, yellow fever, tetanus

*Read before the Tennessee Valley Medical Association at Huntsville, Ala., Dec. 19, 1900.

and many other infectious diseases. One of the most brilliant discoveries in modern medicine is that of Kitasato in pointing out the plague bacillus; another one of very great importance and one that perhaps concerns us more than the plague bacillus, is the transmission of malaria, through the bites of mosquitoes. The honor for this discovery is due Manson & Ross.

Following up Jenner's discovery of preventing smallpox by a modified form of the disease, a great many preventive serums have been prepared with the hope of rendering individuals immune from each particular disease and at the same time act as a curative agent. So far only a very limited number of these preparations have been successful; antitoxine for diphtheria is a well established remedy, and we have good grounds for the belief that antirabic serum will control hydrophobia and that plague may also be successfully treated by an antitoxic serum for this purpose. In this connection DaCosta recently said in an address delivered at a commencement of the Yale University: "The great possibilities that present themselves to stamp out disease by the employment of preventive serums, have led to efforts in all directions to render the individual immune. But for many years to come I think we shall have to be content with the use of the serums in the curative treatment of disease, or where special epidemics like plague, are threatening. With the far from certain knowledge that we possess the enthusiasm which now endeavors in advance of exposure to render the person unsusceptible by injecting him with all possible serums as a safeguard, is not likely to recommend itself to the average parent. Fancy what one would have to go through with in one's youth: to be first vaccinated; to be re-vaccinated; to be injected with the antitoxine of diphtheria as a preventive, with those of measles and scarlet fever when they are discovered; to have the antitoxine of tetanus passed into the body, lest young Hopeful when he cuts his finger should have lockjaw; to be inoculated for typhoid fever as adolescence approaches; to have the antirabic serum used that there may be immunity in playing with the little pet dog; to have introduced into the system the serum of a horse kept in a state of chronic intoxication so as to produce an abiding horror of strong drink; to undergo an injection of anti-venom every time a journey is contemplated to where there are snakes—on a summer trip to Virginia, to the mountains of Pennsylvania, or on a winter trip to Florida. Fancy, too, what might be the state of the blood and the nervous forces in such an all-round immune individual. Who knows but what it may develop a new type of man—not likely a more vigorous type, though immune to everything, even perhaps, to moral corruption."

There are wonderful possibilities and important problems yet to

be solved by bacteriology and as a profession we should encourage private and municipal enterprise along this line, because a general practitioner of medicine cannot be a competent bacteriologist.

The most important question that concerns the profession as a whole today is that of tuberculosis. In our own State 1,000 to 1,500 die annually with this disease. Holmes called it the white plague and Osler the scourge of the race, killing more than 5,000,000 human beings yearly. It is claimed that there are in the United States 1,000,000 people affected with tuberculosis all the time, and I think this a very conservative estimate. In 1898 we had a general epidemic of yellow fever in the Gulf States which resulted in the destruction of about 16,000 human lives. This produced a commotion in the whole nation. Rigid quarantine was established in every section of the country that was stricken with the disease—yet in our own State they die by the hundred every year with tuberculosis—and in 1898, the year of the yellow fever epidemic, 13,000 died of tuberculosis in the State of New York alone. The following report is taken from a recent issue of the Medical Record, showing the number of cases and deaths from contagious diseases in the week ending Dec. 15, 1900, in the city of New York:

WEEKLY STATEMENT.

City of New York, week ending Dec. 15, 1900:

	Cases.	Deaths.
Tuberculosis	210	161
Typhoid fever	104	28
Scarlet fever	171	6
Measles	111	1
Diphtheria	264	37
Laryngeal Diph. (Croup)	12	8
Cebro-spinal meningitis	...	5
Varicella	80	...
Small pox	15	...

It will be seen from the above statement that tuberculosis was the cause of almost twice as many deaths in one week in the city of New York as all other contagious diseases combined. With these awful figures before us everything moves on quietly and as DaCosta observed, received with stolid fatalism being the will of God.

The idea that disease is inevitable should find lodgment only in the minds of those who are superstitious and ignorant.

That consumption is a preventable disease is admitted by all intelligent physicians and sanitariums, and we can make the further positive statement that a large per cent of all incipient cases under proper hygienic treatment and management can be cured. The open air treat-

ment is unquestionably the most successful of any plan yet brought to the notice of the profession. Sanitariums are constructed in Europe for this purpose after the order of pavillions and the patients simply live in the open air continuously, clothing enough is used to keep them warm and the results are said to be better than any other plan of treatment. The method certainly deserves an honest and faithful trial.

We know that it is communicated from the sick to well—the experience of every physician is that the wife has again and again, in hundred, in thousands of cases, contracted the disease from the husband and the children from the parents and from one another—heredity fades into insignificance is nothing when we understand the great principles and truths which Koch has laid down in reference to the bacillus tuberculosis. While it lacks many of the essential features of a contagious disease in the ordinary acceptation of the term, yet it is unquestionably communicable and highly infectious. The house and furniture are known to be sources of infection.

Biggs, in an able article recently presented to the Philadelphia County Medical Society on the subject of registration of tuberculosis, gives some interesting maps showing the prevalence of the disease in certain localities in the city of New York. In this article he makes the following pointed statements:

1. "Tuberculosis is an infectious and communicable disease, produced by the tubercle-bacillus.

2. "There is no satisfactory proof that the tubercle-bacillus multiplies outside of the living body under natural conditions; it follows as a necessary sequence that every case of tuberculosis is produced by the reception of the same identical tubercle-bacilli, which have been thrown off by some other human being or by some animal suffering with tuberculosis.

3. "The tubercle-bacilli producing an infection are generally obtained from dust contained in the air breathed, or in the drink or food taken.

4. "The tubercle-bacilli thrown off by a person or animal suffering from the disease, are contained solely in the discharges from the tuberculous tissues, and it should be possible to absolutely control their dissemination.

5. "It follows, therefore, that tuberculosis is preventable, and (in the early stages) clinical experience shows that it is curable.

6. "It is by far the most fatal disease with which we have to deal, and from both an economic and sanitary standpoint, is of vastly greater importance than any other infectious disease, both because of the number of deaths it causes, and the suffering it produces. Its importance is further enhanced because it occurs to the greatest extent

in the working period of life, and its victims are cut off at the time of their greatest usefulness.

7. "Its prevention requires the exercise of enlightened cleanliness on the part of its victims, which pre-supposes education, suitable hospital accommodations for the care of advanced cases among the poor, and efficient disinfection of dwellings. These ends can no more be attained in tuberculosis without registration than they can be in the contagious diseases."

The opposition to the registration of tuberculosis is rapidly fading away in the face of the facts that it is a communicable disease and that it is possible to control the dissemination of the bacilli and in this way prevent its spread. It is a step in the right direction; it does not work a hardship on the patient; it has lowered the death rate from this cause in the city of New York. In Germany it is made compulsory by law with a view of preventing the disease from spreading. This great question of the prevention of tuberculosis has attracted the attention of the physicians and sanitariums of the world. Think of the congresses that have recently been held for the sole object of discussing this question. Societies are being organized for the purpose of studying tuberculosis. Only a few weeks ago a society of this kind was organized at the Johns Hopkins Hospital. Wm. Osler, in introductory remarks at this organization, said: "The history of the acceptance of any great truth in medicine is an interesting study. A slow, gradual recognition seems essential to permanency and stability. As Locke well said, 'Truth scarce ever yet carried it by vote anywhere at its first appearance.' Even in this electric age the practical application of new knowledge is singularly tardy. Antiseptic surgery took twenty years to win its victory, and for about the same period we physicians have been participants in another long warfare, the successful outcome of which may be said to be now in sight. The twentieth anniversary of the discovery of the germ of tuberculosis by Robert Koch, is near at hand—a discovery which in far-reaching results, will prove to have had few equals in human history. Since 1881 the laboratory phase of the question, with its experiments and researches, has so far been the most complete; the clinical side has been enriched with two facts of supreme importance; first, the earlier and more positive diagnosis of the disease; and, second, a fuller knowledge of the means for its cure; and we have now entered upon an economic stage, and the tuberculosis leagues and congresses, laws and enactments, show how alive we have become to the importance of the disease in national and civic life."

The Queen of Holland, at her coronation, set an example that is worthy of imitation by the civilized world. Whether she was actuated

by an accurate knowledge of the true nature and the means to be adopted to prevent the spread of this awful disease or a divine influence to do good to humanity, it matters not. She set apart a large sum of money for the establishment of a sanitarium for the consumptive poor—recently the State of New York has appropriated considerable money for the building of an institution of like character. With our present knowledge too much stress and importance cannot be attached to movements of this kind. Operating upon these lines a bright ray of hope seems to rise up in the future, and it is the only route through which there is any encouragement. What does the average physician do in this country for a case of consumption? He sees the patient, makes an examination, gives directions about diet, prescribes, and the disease goes steadily on to a fatal issue. Another member of the family takes it and another and another till sometimes almost or all of the family has died with tuberculosis—if the doctor does anything at all with credit to himself, it is to collect his bill and a great many times he fails in this. Have you ever stopped to think how long the doctor and patient have been carrying out this program? The people are very patient and persistent in calling on the doctors in these cases—they do not know what else to do. Not long since I was staying day and night with a young man who had had a hemorrhage in typhoid fever. The mother would ask every few minutes: "Doctor, do you see any change in my son? I know you do not like to be worried so much with my questions, but this is all I can do. I trust first in God and then in my doctor."

Asylums for the care of the insane have been established with specialists in mental and nervous diseases and trained nurses in charge. This is very commendable in any State, in fact it is necessary because any one who is insane is liable to do violence to his family or some other person. We have in some of the States homes for those who have epilepsy. In the State of New York they have what is known as the Craig Colony for epileptics—this, I am sure, meets with the approval of every physician and intelligent person who has investigated the subject. If one member of a family has epilepsy the family is not only deprived of the help of this one, but it usually requires the assistance of one or more of the family to take care of the person so afflicted. Not long since I was called to see an epileptic child who had fallen into the fire and received a fatal burn. I would be glad to know that our own State would, in the near future, establish an institution of this kind. Our sister State has established in the city of Atlanta a Pasteur Institute for the care of those who are suspected to have hydrophobia, and it is maintained by a tax on dogs—this, too, is commendable in the highest degree—but all these institutions with

their great and noble work combined cannot equal in importance the control of this one disease—tuberculosis. Dr. Blake has shown, in a very efficient and conclusive manner the importance of the State taking steps to separate the tuberculous from the non-tuberculous convicts—and I do not wish to be understood as under rating Dr. Blake's efforts along this line, but I do say that it is vastly more important for the State to adopt measures for the control of the disease at large in the State than for her to make an effort to control it in the convict camps. Suppose it were possible to collect all within the borders of the State of Alabama, who are subjects of tuberculosis to some suitable sanatorium that is fully equipped for this purpose, with laboratory, experts and trained nurses, and every house from which these patients were removed were thoroughly disinfected, (in some cases it would be necessary to burn the buildings) I believe that in five years if this system were carried out efficiently instead of 1,000 deaths yearly from tuberculosis there would not be over 200. I as much believe that we can as certainly control tuberculosis in this way as we can any other contagious or infectious disease.

BRONCHO-PNEUMONIA.

By F. P. HIXON, M. D.,

PEROTE, ALA.

Broncho Lobular or Catarrhal Pneumonia as a distinct disease from Lobar or Crupous Pneumonia was unknown previous to 1838 and its true pathology was not clearly demonstrated until 1844.

It is almost always a secondary disease due to extension of inflammation from the bronchial tubes into the alveoli; it is very prone to follow bronchitis of the infectious diseases, measles, whooping cough, scarlet fever, diphtheria, influenza, small pox and typhoid fever.

Broncho-pneumonia prevails during the winter and spring, exposure to cold being often an exciting cause. It occurs in the very young, the very old, and in persons debilitated from any cause. It is often due to inhalation of particles of food, dust, irritating gases, products of acute or chronic inflammation of the pharynx or larynx or hemorrhage into the respiratory tract, but the most common cause is the inhalation of infectious bacteria.

"Catarrhal pneumonia is an inflammatory process resembling Lobar pneumonia in that there is an exudation into the air vesicles of an albuminoid fluid, containing red and white corpuscles and endothelial cells, but unlike it, there is very little fibrin formation and very little mucus as in general catarrhal inflammations. The name Lobular is not accurate, for the process may be seen in Hypostatic pneumonia, in

which the contents of the alveoli are catarrhal. The lung is congested and upon its surface are seen sunken purple patches of atelectasis. There is marked engorgement of the blood vessels, and the capillaries are tortuous and project into the air vesicles. The lung tissue is usually more moist and smoother than in Lobar, though small nodules the indurated lobules may be felt.

"Beside the atelectatic patches there may be seen pneumonic patches which resemble the former except that the surface is raised and about each of which the interlobular septa may be distinguished. Later these purple patches may become fused, involving a considerable portion of the lung. Upon microscopical examination we find the affected lobules to contain three zones.

"In the center is the small bronchus, having thickened and granular walls.

"Around the bronchus the air vesicles are filled with catarrhal cells and very little fibrin. In the outer zone there is capillary congestion."

Catarrhal pneumonia may terminate in resolution by means of fatty degeneration and discharge of the exudate. In fibroid phthisis, and in rare cases in abscess or gangrene.

The onset of broncho-pneumonia, particularly when it is secondary to some other disease, is often so gradual and destitute of leading symptoms, especially at the beginning, that it is often overlooked. Occasionally at the period the pneumonia develops there is a well marked accession of fever and dyspnoea, the temperature running to 102 to 104 degrees, the dyspnoea is often so intense as to threaten suffocation; it is always proportionate to the extent of inflammation and augments with the progress of the disease." The cough is dry, hard and painful, often occurring in paroxysms. Soon signs of deficient aeration of the blood are noticed, the face becomes suffused, the finger tips bluish. The respiration is hurried, but the rapidity is not always proportionate to the extent of inflammation, it is often irregular, the irregularity coming on at an early period. The pulse rises to 150 or over. The skin is dry and hot; the tongue coated; the bowels are constipated usually; the urine is scanty and high colored; the sputum is viscid and scanty and often streaked with blood, later it becomes muco-purulent. "The physical signs are often obscure, from the nature of the case, but they are of primary importance and it is often by them alone that a correct diagnosis can be made; while it is only by them also, that the extent and progress of the local disease can be determined. In the majority of cases broncho-pneumonia is double—the disease, however, being frequently much more extensive on one side than the other. Inspection shows in children panting and shallow respiration,

inspiration being short and expiration prolonged, the alae nasi widely dilated, the upper portion of the chest heaves while the lower portion and abdominal muscles are drawn in during inspiration. Cyanosis occurs to a variable degree and may be observed in cases where the disease extends over a considerable area. Palpation is usually negative.

"Percussion. There is dullness in proportion to the amount of consolidation and dullness will be over the seat of disease, usually posteriorly over the lower lobes. Percussion should be gentle, and by using the finger as a pleximeter, a feeling of resistance afforded by solidified lung substance can often be detected."

"On auscultation the physical signs are at first limited to the mucous and subcrepitant ronchi, dependent upon increased secretion of mucus in the bronchi. The subcrepitant rales are frequently continued throughout the attack and are often the only stethoscopic signs present. Bronchial respiration becomes developed when induration has extended to a considerable portion of the texture of the lungs. It is chiefly heard at the upper and middle portion of their posterior part—it is rarely heard in the lower lobes from the comparative smallness of the bronchi and their early obliteration by the progress of the inflammation. The inspiratory murmur is short, obscure, and almost without the vesicular murmur and may or may not be accompanied with the mucous or subcrepitant ronchus, the expiration is rarely distinct unless the bronchial respiration is fully developed, when it is usually louder than on inspiration. The sounds indicative of inflammation of the texture of the lungs are often entirely obscured by the mucous ronchi of bronchitis."

The diagnosis of broncho-pneumonia is often a matter of influence rather than of actual demonstration, if the disease is confined to one or a few small foci it may entirely escape detection. "The diagnosis largely depends upon the evidence of a bronchiolitis as indicated by increased elevation of temperature, rapid breathing, dusky skin and subcrepitant rales in the sequence of a bronchitis in childhood or old age, and depending upon an obvious cause or occurring in the diseases previously mentioned, especially in measles and whooping cough and the constitutional symptoms being out of proportion to the local lesion." "It is to be differentiated from lobar pneumonia by its more frequent occurrence at the extremes of life, by the presence of the signs of a capillary bronchitis or of a hypostatic infiltration instead of a lobar solidification, usually in both lungs instead of being limited to a single lobe, also by a less abrupt onset and a more prolonged course." Its termination is by lysis instead of by crisis, the sputum is muco-purulent, while in lobar pneumonia it is usually rusty. Catarrhal pneumonia is usually due to mixed infection while crupous pneumonia is always caused by the pneumococcus.

Broncho-pneumonia is one of the most fatal diseases of childhood. "In large cities it ranks next in fatality to infantile diarrhoea," perhaps between 30 and 50 per cent. of all cases die.

In convalescence from febrile diseases, especially of measles and whooping cough, it is very important that the child shall not be exposed to cold, especially at night when the temperature of the room naturally becomes lower. All catarrhal affections of the nose and throat should be carefully attended to. During fevers the mouth should be kept clean with antiseptic solutions. By using these precautions an attack can often be prevented.

"The special indications in the treatment of broncho-pneumonia are to check extreme elevation of temperature, to promote ease in breathing, to stimulate circulation and respiration and to offer a suitable diet."

The air of the room should be kept moist and at an even temperature. Some of the common saline fever mixtures should be given and if the disease comes on abruptly with high temperature a little aconite may be added. Cold water is an excellent means of reducing the temperature. The pain, distressing symptoms and incessant cough may at times demand opium and Dover's powder will be found the best opiate for children. The diet should be light and easily assimilated; it should consist of milk, if it agrees, but it often curds and is disagreeable. Broths are often satisfactory. One of the best forms of nourishment and one that is easily procurable is egg-water. The white of an egg is thoroughly stirred in a half glass of cool water. This forms a pure and easily assimilable albumin water. This may be flavored to suit the taste, and forms an excellent medium for the administration of stimulants. If the vitality begins to fail brandy may be begun early. The patient should be encouraged to drink cold water freely. Stimulant expectorants, squill, carbonate of ammonia or Aromatic Spirits of Ammonia should be given for the cough. If there is difficulty in getting up the mucus an emetic preferably of ipecac should be given. It is often necessary to apply some form of counter-irritation to the chest, a mustard plaster or mustard jacket is perhaps best, but it should not be allowed to blister. During an epidemic of capillary bronchitis, (and clinically it is impossible to distinguish this disease from broncho-pneumonia) in Alexandria, Va., in the winter of 1869-70, twenty cases were treated by Dr. Bedford Brown a report of which was published in "The Medical Journal of the Medical Sciences," October, 1870. All of the cases were treated with ipecac; in large doses as an emetic to remove mechanical obstruction from mucous exudation into the bronchial tubes, in medicinal doses for an alterative effect on the local disease, in minute doses as an anti-emetic when the

stomach was irritable. In most cases in connection with ipecac he used quinine and brandy and kept warm, moist cataplasms applied constantly around the chest and over the abdomen, when enlarged and distended regardless of temperature. All of the twenty cases treated in this way recovered. One case treated mainly by expectorants, diffusible stimulants and counter-irritation was lost. The results were indeed remarkable when we remember that the mortality rate in this disease is always high.

In this paper I have quoted freely "The American System of Practical Medicine," "Practice of Medicine," Osler; "Hall's Pathology," "Watson's Practice of Physic," "The American Journal of the Medical Sciences." (Physical Diagnosis page.)

ECLAMPSIA.

By E. O. WILLIAMSON, M. D.

GURLEY, ALA.

Definition.—A pure symptomatic disorder, characterized by convulsions or epileptiform seizures that come on suddenly, prior, during, or after labor.

ETIOLOGY.

Eclampsia is the result of Toxaemia, which may and does result from quite a variety of causes. The belief that long prevailed that the pressure of gravid uterus upon the renal veins caused albuminuria, it in turn produced the convulsions and train of symptoms known as eclampsia. This belief complicated the study of puerperal convulsions for there is not now any reason to believe that it had the least to do with eclampsia, during pregnancy the blood alters in quality and in quantity. There is a great increase in white blood cells and decrease below the normal of iron and albumen as the old saying goes, the blood becomes more watery, so to speak. The cell activity throughout the whole human anatomy is greatly increased. Nature takes on new life and vitality; also an impression is made that makes the acute highly tuned nervous system respond to its highest point. The result is great cell activity throughout the whole bodily structure and as a consequence of this immense cell activity excrementitious substances greatly increase in the system, the secretory organs are busily at work, and when the balance between secretion and excretion is disturbed then you have the true cause of eclampsia, be that found in kidneys, lungs, liver or intestine. In the pregnant woman the balance between secretion and excretion is easily disturbed and any woman who becomes pregnant with either diseased excretory or secretory organs is in grave danger of eclampsia because they are

more easily brought into a state of toxæmia than those whose organs both secretory and excretory are normal. Toxæmia may result and this is the most often form of toxæmia, a failure of the kidneys to take out from the system the excrementitious substances and thus the blood becomes poisoned. You may or may not have albuminuria. You will have albuminuria if you have any nephritis, but possibly albuminuria is only the effect of the toxæmia upon the glandular structure of the kidneys; then albuminuria becomes a very important symptom, but that it is not always present is a sure symptom that its absence does not always mean that the danger of eclampsia is not near. Still on the other hand you may have a diseased kidney, albuminuria thus showing nephritis, and at the same time have no eclampsia, because the other eliminative organs take the place and act vicariously, viz.: liver, lungs, intestines, failure to eliminate from the lungs and intestinal tract have quite a good deal to do with rendering the blood free from poisonous influences, hence any failure here could and possibly would produce eclamptic seizures. I think in a great many cases eclampsia produced by faulty liver function conditioning an incomplete oxidation and as a consequence the production of carbonic acid gas, and these poisons whether produced by faulty function of kidneys, liver, lungs, intestines, will produce one and the same effect. Toxæmia of the blood which acts and exerts its deleterious effect on the nerve centers or at least motor centers of the cerebrum and they produce eclamptic seizures; the attack reminds me of a great surplus of energy stored up when nature lets it go produces a powerful effect.

SYMPTOMS.

The doctor who systematically makes the examination of the pregnant woman's urine whom he has had placed into his hands for safe keeping, will not be usually found napping, not alone for albuminuria, but for urea and keeps check of the amount of urine passed during the 24 hours. With diminished urea the danger of toxæmia increases. The clinical history of eclampsia is rather variable, but as a rule we have premonitory symptoms that usually tells us a climax is reached and that trouble is rapidly coming. We may have intense headache, persistent, thus showing the heavy laden poisoned blood is producing its effects on the brain which will sooner or later burst into electric shocks, as it were, if not checked. We also usually have dimness of vision and if you will now examine your patient's urine you will find diminished urea and may or may not find albuminuria, owing to whether you have nephritis or not; if you have nephritis you now have a new danger for one of your excretory organs is badly impoverished. You can determine insufficiency of the kidneys by measuring the whole amount of urine passed during the 24 hours. You will usually

have in all but anaemic patients increase of arterial tension. If you have renal disease as a complication as well as one of the factors that is producing the toxæmia you will quite likely have a dropsical condition, especially puffiness of eyelids and swelling of lower limbs—the symptoms of the seizure are quite familiar to you all and quite characteristic. I shall never forget my first case; it scared me so I almost made a retreat. I finally summed up courage enough to stand my ground. The wide open eyes fixed in a vacant stare, the small contracted pupil, the rapidly opening and closing eyelids are pictures that are quite familiar and one which always makes me shudder. They make a train of symptoms which I think for violence has no equal. The heart's action becomes irregular, the face cyanosed and the breathing stertorous; the convulsions soon pass from clonic to chronic in their character; the eyelids become fixed and you may now have opisthotonos; the number of seizures are variable, there may be 100 or more during the 24 hours. They usually last from one-half to one minute. I have seen them have three or four convulsions, one after another, ten perhaps. There would be no interval until they have had a dozen or more. During the seizures the patient is not conscious, but at first during the intervals she is conscious, but usually passes into a state of unconsciousness after she has had them for a few hours.

PROGNOSIS.

In recent years the mortality of the mother has been greatly lessened until we do not recognize eclampsia now as being a very fatal trouble. Years ago mortality used to be 30 per cent., now hardly 3 per cent.; the mortality of the child remains at about 50 per cent. or about one-half the cases die.

TREATMENT.

When the pregnant woman has been carefully watched by her physician then we would very seldom have a case of eclampsia to treat. I do not say it would never exist, but it would be quite rare indeed; then we, as physicians, ought to educate the people that it is absolutely necessary when their wives become pregnant that their indispensable duty is to put her into the hands of her attending physician, where her condition can be looked after and her symptoms carefully watched, and not wait until she is in labor to go after the doctor. If necessary, we ought to refuse to attend any case of labor unless we have had the case under our care and attention. Teach your patient the importance of keeping up free action of sweat glands by frequent baths and brisk rubbing of the skin. Keep the bowels open by free, mild purgation; take abundant outdoor exercise. Pregnant women, as a rule take too little exercise out doors in open air; when all the excretory organs are performing their function all the substances are

eliminated, which, if retained in the body, would produce toxæmia and consequent eclampsia, but when we have bowels, skin, lungs, kidneys clogged we have everything we need to produce a fit. When we find the symptoms in pregnancy present that we recognize as symptoms of toxæmia we should at once go to work by hygienic and diatetic measures to overcome them and if such measures fail then medicinal and surgical treatment are brought forward. Standing among the first thing is a diet of sweet milk, place your patient on a diet strictly of sweet milk, produce mild, but free catharsis of the bowels, and a good remedy is Epsom Salts in broken doses.

The best preventive treatment when the prodromal symptoms appear is not to risk so much to medicine or the effects of drugs, but to have your patient drink freely of large quantities of water, irrigation of the bowels, with large quantities of warm saline solutions, thus producing and promoting the action of kidneys, skin and keep the intestinal tract free from excrementitious substance. Treatment for attack: there are no specific treatments. Sometimes one line of treatment will succeed when again it will fail. Where you have arterial tension high I think venesection is a good remedy, but it should not be abused, but this sometimes produces a sudden cessation of the convulsions.

Verat. Vir. has a good effect in the same class of cases, 10 to 15 m given every hour or so, the pulse reduced to 50 or 60 per minute. I think morphine very objectionable because it defeats the prime object you are trying to produce: elimination of the poison, thus adding fuel to the rapidly increasing flame and besides in the use of chloroform you can get very much better results than with morphine. When these means fail to control the seizure, surgical treatment called for which is empty the uterus as quickly as possible and the nearer your woman is to full term the easier the task will be. I have most often used my index and middle finger for dilating the uterus, for the cases I have had are those in which I have not had any time to wait on the slower processes of packing the cervix.

I have a case now to report on account of its peculiar etiological factor. Mrs. U. H. H., age 21, first pregnancy. Was called at 2 o'clock at night to see my patient about 7 miles from town. I arrived at 3:30, found my patient in an eclamptic seizure, having three convulsions, one right after another, and then an interval of 10 to 25 minutes, then a repetition of three convulsions again. She being a large, plethoric woman; vascular tension high. I perform venesection, took about 1 1-2 pints dark blood, very dark; convulsions continued. I then resorted to Verat. Vir.; convulsions continued; chloroform narcosis relieved the intensity of the seizures, deciding on emptying the uterus, I found the cervix dilating. I dilated rapidly with by index and

middle finger, head came down. I applied forceps and delivered; her convulsions still continued. I gave her a dose of 40 grains chloral, 60 grains Bro. Pot. per enema; she was under influence of the chloral, which to some extent, controlled the attacks, but not entirely. I came hours after first dose quinine. Till 30 grains was given temperature went down to normal; I then gave her some warm saline solution and she went to rapid convalescence. I will here add I made repeated examinations of the urine and never even found a trace of albumen.

SCARLATINA.

By W. M. CUNNINGHAM, M. D.,

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The purpose of this writing is to call the attention of practitioners to the prevalence of a mild or atypical form of scarlet fever which I understand is prevailing to some extent in some sections of the State, especially in Fayette, Walker and Jefferson counties. If any other apology should be offered for this article it is the fact that too much may hardly be said in the way of a discussion of preventive measures, when we come to consider so formidable a disease as scarlet fever; and while the disease, as it occurs in my section is on the average a mild affection, yet a few cases probably as high as 10 per cent. are of moderate severity.

The disease first made its appearance in my section sometime in September by one or two isolated cases widely separated from each other, between which no communication had been had. Some of these cases were in large families of children, who had never had the disease, and without any precaution no further cases occurred in the families referred to. The disease, therefore, does not seem to possess that degree of contagiousness ordinarily belonging to scarlatina. Later, however, I have known whole families to be affected and I am now using more rigid measures to stop its progress.

The average case presents about these symptoms: Slight chilliness, quickly followed by a rise of temperature, the child vomits; a bright redness may soon be seen in the throat, and in 24 to 36 hours a bright scarlet rash appears—sometimes on the face, neck and throat first, sometimes on the lower extremities first. The cervical glands swell and we thus have the clinical picture of scarlatina. Quite frequently, however we see so little characteristic of the disease in cases we are called to see that we are apt to either overlook it entirely or pass it by as some trivial affection and thus allow the disease to be propagated indefinitely. There is a disposition on the part of practitioners in some sections, owing to this mildness of the disease to doubt or deny the identity of it with true scarlatina. I have just read an article in the New York Medical Record, Nov. 10, in which the author claims the

existence of a separate and distinct exanthem from either Rubella, Rubella, or scarlatina, and bearing a striking resemblance to the last, which he designates as the "fourth disease." The present malady may be this, but the severer cases present about all the characteristics of true scarlatina. Desquamation, nephritis, albumen in the urine, otitis and the other less common sequelae, are all met with—not in all the cases, but some of them in some cases. It stands to reason that if the severer cases are scarlet fever, and I think there can be no doubt of it, the milder ones must be, since these propagate the former and vice versa.

What is our duty as promoters of public health, in the management of this disease? The following is the very least that should be expected of a practitioner under whose care a case has been placed. Stop all visitors to or from the house, allow as little contact or mingling between the patient and other members of the family as is consistent with proper nursing, comfort and good sense. Put all clothing worn by the patient into boiling water as soon as removed from him, completing the laundering by thorough boiling. When desquamation has ended, give the patient a warm bath in Bichloride mercury 1-5000, including the scalp. The floor and such woodwork in the room and articles as have been handled by the patient should be scrubbed with the bichloride solution 1-1000 or stronger. When the patient himself has been put in safe condition remove him from the room, close it and vaporize in it a 40 per cent. solution of Formaldehyde for not less than six hours. Where nothing better is at hand this can be done by suspending a tin cup containing sufficient of the solution over a lighted kerosene lamp, regulating the flame and the distance of the cup so as to produce the desired amount of evaporation. A little airing after renders the room habitable. Better and more thorough measures should be adopted when practicable. I cannot conceive of a case situated so that the above measures could not easily be carried out. The Formaldehyde and the Bichloride are both inexpensive and are either always at hand or can be procured easily.

What the outcome of this disease, if uninterrupted, will bring us, is uncertain, to say the least. While still remaining a mild affection, it may run the gauntlet, as it were, with only a slight mortality. More probable, however, it would assume a more virulent aspect, and furnish the undertakers with a flourishing business. I have purposely omitted considering many important facts in connection with this malady, including the treatment, as it would be impossible in this short article to consider these, my chief aim being to get the attention of physicians directed to the disease which in some localities, is being overlooked entirely or treated as a simple non-contagious affection, being convinced that in the hands of my able medical brethren this matter when brought to their attention will be properly considered,

Selected Articles.

PREVENTION AND MANAGEMENT OF INFECTION OF THE BREAST DURING LACTATION.*

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It is almost unnecessary to refer to the importance of this subject. The facts that the majority of nursing women have wounds of the nipple of greater or less extent, that these wounds result in much suffering, that they frequently become infected, that the infection often extends to the breast and causes abscesses, and, not infrequently, long-continued suppuration, show that the management of the breast is one of the most important obstetrical questions. Moreover, the fact that the disturbance of the breast is the cause of much sickness and mortality among infants, makes this an important subject of paediatrics.

At the beginning, I wish to call your attention to the distinction between infection of the breast and simple hyperæmia or congestion of the breast. This distinction is necessary, for it is important that the difference between the two conditions should be kept in mind. The establishment of the milk secretion is always attended with more or less painful congestion of the breast, and, later, the breasts are liable to become painfully distended whenever the interval between nursings is unusually prolonged. Infection of the breast, on the other hand, is generally attended with fever, and while it is often confounded with simple congestion, it is entirely a distinct process.

Formerly we heard much of the so-called "milk fever" that comes on during the first week of child-bed, about the time of the swelling of the breasts, and was attributed to the establishment of the milk secretion. It is now well proved that this fever is due to genital wound infection. While the secretion of milk, like the secretion of other glands, is attended with a very slight local rise in temperature, this increase in heat amounts only to a few hundredths of a degree, can be measured only by a delicate thermometer, and cannot properly be called fever. Hence the term "milk fever" should entirely be abandoned. If there is no infection, there is no fever. We have, therefore, to consider only the nature, cause, and the diagnosis of infection of the breast as a basis for the study of its prophylaxis and treatment.

It has been found that the *Staphylococcus pyogenes aureus*, the

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Staphylococcus pyogenes albus, and in some cases the *Streptococcus pyogenes*, are the infecting germs. It is well known that the staphylococci always, and the streptococci frequently, are found on the skin and in the ducts of the cutaneous glands. They are found, not only around the nipple, but also in the milk channels, and in the milk drawn from sterilized nipples. While it is doubtful if the *Streptococcus albus* found in the milk is the cause of infection, even if there is an abrasion of the lining membrane of the milk ducts, there can be no doubt that the bacteria found in great numbers on unclean nipples are a source of danger. Various sources of contamination are the clothing, the fingers of the mother and nurse, and the face and hands of the child. The mother's nightgown, the child's dress and bib, often soiled with overflow milk, are frequently contaminating agents. The fingers of the mother or nurse, perhaps soiled by coming in contact with lochial or fecal discharges, when used to draw out the nipple, or cause its erection for a better application of the child, are a common source of infection. Perhaps one of the most dangerous infecting agents is the head or the hand of the child. For several years I have noticed that severe infection generally occurs in patients whose babies have boils or pustules on the body, or sore eyes. The pustules open spontaneously, and the pus, smeared over the face of the baby, is rubbed into the nipple when the child is put to breast.

There is some dispute between those who hold that germs enter the breast only through the nipple by way of the lymphatics and those who believe that the milk passages are also routes for infection. The general presence of an abrasion in the epithelial layer of the nipple in cases of infection, and the direct route from the erosion to the depth of the breast furnished by the lymphatic channels, which are favorable routes of most pathogenic bacteria, favor the now generally accepted conclusion that the latter is the route of breast infection.

The diagnosis between infection of the breast and simple congestion, on one hand, and genital wound infection on the other hand, is very important. Simple congestion of the breast is generally important, as a disturbing factor, only during the first days of lactation. While it is often attended with the tenderness which is characteristic of an infection, other symptoms, namely, chills, fever, etc., are absent. As soon as these symptoms develop, all doubt concerning the diagnosis between congestion and infection of the breast must cease.

The diagnosis between genital wound infection and breast infection must be made by a study of the predominant local symptoms. The greatest difficulty is experienced when symptoms of infection coincide with pelvic tenderness, distension of the breast, and soreness of the nipples. In such a case the determination may require some delay.

An important point in diagnosis is the determination of the question whether the infectious process has resulted in the formation of an abscess or not. The centre of the infection and abscess formation is often quite deep, and the determination of fluctuation is difficult. The use of diagnostic aspiration with the large hypodermic needle is in such cases the proper procedure. If fever or local pains continue for more than two or three days in spite of proper treatment, the diagnostic puncture should be made.

Coming now to the subject of the paper, the prevention and treatment of breast infection, we first have to ask, What, if anything, can be done to prevent infection before lactation begins? The laity, as well as the profession, quite universally believe in various local applications, sometimes astringents and sometimes ointments to the nipple. To develop a retracted nipple, some kind of a suction apparatus is frequently used. The latter I believe to be of very doubtful value, and not to be commended. Fatty substances on the nipple serve as bacteria catchers and so are of questionable propriety. The tanning of the skin of the nipple by astringents will not last long after nursing begins. I believe all that need be done is to give attention to cleanliness during pregnancy, and especially careful washing of the nipple with soap and water. In this way the skin of the nipple is made healthy and resistant, and there will be no accumulation of bacteria when the child is first put to breast.

In this connection it is important to remember that a person in good health resists infection better than one with poor digestion, poor circulation, and poor excretion. Every one has observed how differently infection develops in different patients, and we may conclude that these differences are due to variations in the resisting powers of the patients. If two women have similar wounds, contaminated with bacteria from the same source, one will become infected, and the other remain unharmed, because the tissues of one immediately resist the invasion of the germs, and the tissues of the other do not. It is also a common clinical observation that in one patient an infection may begin in the breast, and in a few hours may disappear completely, while in another patient an infection of the same kind may persist, apparently disappear for a few days, reappear, and eventually terminate in an abscess. Such differences in the progress of breast infections, like similar differences in infection of other parts of the body, must be explained by differences in the resistance of different individuals.

It therefore follows that all measures tending to the improvement of the general health, both before and after confinement, are most important in the prevention of breast, as well as all other, infections.

In child-bed or after nursing begins the two principles of prophylaxis are to avoid contamination with bacteria, and to avoid or heal as quickly as possible the nipple wounds. To meet the first indication, it is necessary to remember the most important sources of infection. The common practice of nurses and patients of taking hold of the nipple with the fingers to draw it out for the child to grasp, is quite unnecessary and should be forbidden. When the nipple is not erected spontaneously, a little pressure on the breast outside of the areola is generally sufficient. If it should seem necessary to take hold of a retracted or flat nipple, the finger should be protected by sterilized gauze.

The danger from the child is from pus escaping from boils, pustules, or sore eyes. The pustular eruption on the neck and face of the child resulting from the easy inoculation of its tender skin with pus germs, is a source of great danger; for the unobserved rupture of a single pustule, and the scattering of its bacteria, is the most common source of infection of the nipple. The management consists in the careful opening of each pustule when it is ripe, the surrounding skin having been thoroughly washed with alcohol, and the evacuation of the matter, leaving the open pustule for some time covered with cotton saturated with alcohol. If the open pustule is on the face, it may be closed up by a small drop of collodium. When the face has been contaminated with matter from sore eyes it should be carefully washed before nursing. If one is uncertain how well the washing is done, it is safer to use a nipple shield until the danger is past.

Suppuration in the glands of Montgomery, while not very common, is, while it exists, an important source of danger. Some mechanical injury produced by the nursing child, or by a badly fitting nipple shield, may set up an infectious process. The proximity of the nipple makes such a suppurating gland dangerous. It should be opened like the pustule on a child, and should then be sealed with collodium during nursing.

The general precautions consist in washing the nipple with clean water before nursing, and washing them after nursing with 75 per cent. alcohol, to protect the nipple abrasions from accidental infections from the mouth or skin of the child, and in covering the nipple always with sterilized gauze laid over the breast or attached to the shirt, to prevent contamination with soiled garments or bedclothes. As a disinfectant, alcohol is chosen because it is harmless to the child, and at the same time fairly efficient. Other disinfectants, like carbolic acid or sublimate, cannot be used on account of the danger of poisoning the child. The popular boric acid is of very little disinfectant value, and is practically worth no more than water.

The liability of the nipple to abrasions and wounds depends con-

siderably upon its shape, size, and formation. The most serious wounds, like deep transverse and perpendicular fissures, are due to malformation of the nipple.

When the nipple is small and not easily grasped, or when, because of the small size of the openings of the ducts, the milk flows slowly, the child must pull very hard on the nipple, and the chances for the production of abrasions are increased.

The length of time that the child is at breast is also important. If the child is nursed for half an hour, or one hour, or lies at the breast practically all night long, the nipple is, of course, macerated, and wounds are easily made and infected.

For prevention of wounds of the nipple, as well as as for their cure, the nipple shield is of very great importance. Properly made and used, it not only saves the mother from much suffering, but also protects her from the dangers of infection. Many of the shields on the market are improperly made. Frequently they are too short, and the nipple cavity ends in a small opening, into which the nipple is drawn and pinched. Frequently the shields are too small and the nipple is painfully constricted at the base. The flange is often too narrow and improperly formed. The rubber shield does not afford sufficient protection. The flange should be smooth, flat, and nearly at right angles to the bowl, and large enough to cover the areola. The bowl or nipple cavity should be so large that the nipple is not constricted, cylindrical in shape, and deep enough so that the nipple is not pulled too firmly against the end. It may open into a small bulb which serves as a milk reservoir. Such a shield may be used temporarily or intermittently as the case may require, during the first four weeks of lactation. Attention should be given to its care, that it may not become a source of danger. The nipple should be removed and thoroughly washed after each nursing. After washing it outside, it should be turned wrong side out, and the inside thoroughly washed. Then it should be dried with clean gauze and placed, together with the shield, which has also been thoroughly washed with running water or boiled, in a piece of clean gauze. The common practice of putting the shield unwashed into a cup of boric-acid solution and letting it stand for hours is an abomination that should not be tolerated.

When nipple wounds become infected, but before there are any symptoms of general infection or involvement of the deeper breast, the local wounds may be treated like similar wounds in other parts of the body. The application of cotton saturated with alcohol is generally efficient. Nursing through a shield may be allowed.

The appearance of the symptoms of chills and fever generally indicates a deep infection of the breast. When this appears, nursing from

the affected breast should be entirely stopped, and the breast should be supported and put at rest by a proper bandage. Treated in this way, from eighty to ninety per cent. of all breast infections will terminate without abscesses. The nipples will heal, and the infective process will be localized and controlled by Nature's inflammatory reaction. Should an abscess form under this plan of treatment, which will happen very rarely, it will be small and confined to one lobe, or part of a lobe.

For supporting the breast and putting it at rest, the simplest form of bandage will often suffice. This is a plain piece of muslin six or seven inches wide, encircling the chest. Its mode of application is very simple, but important. The nurse should distinctly understand that the breast is to be raised and supported, not compressed; with the patient lying on her back, the bandage under her, the nurse takes hold of one end of the bandage with one hand, and of the corresponding breast with the other, and draws the breast up to the middle of the chest, holding it there with the bandage; the patient is then directed to hold the breast in this position with the hand of the same side, the fingers being extended. Then the other breast is raised and held in the same way, after which the bandage is fastened by several safety pins, the lower border being drawn more tightly than the upper. If the bandage tends to slip down because the patient moves around more or less, strips of bandage over the shoulders may be used to hold it in place.

The double Y bandage holds the breast better than the circular bandage just described. It is made of strong cotton cloth, and consists of a back piece four or five inches wide, and fourteen to twenty inches long. To each end of it are strongly sewed two diverging strips, each from four to five inches wide, and about thirteen inches long. The lower limbs of the Y's which go under the breast are fastened together in front with safety pins, then the upper limbs in the same manner. The upper and lower limbs of the Y's in front may be fastened together with safety pins, to support better the inside of the breasts. With this bandage the nipple of the sound side may be left free, so that the nursing of the child will not necessitate the unfastening of the bandage. If the circular bandage is used it must be unfastened every time the child is nursed from the healthy side, or an opening is made to allow the child to be nursed, it will be necessary to protect the nipple and areola by a pad of gauze inserted under the bandage.

Another form of bandage that may be used with very good results, especially in cases of infection of both breasts where nursing must be entirely stopped, is that recommended by the late Dr. P. A. Harris. It is a roller bandage, and its mode of application is somewhat difficult to describe, although quite easily understood when one sees it applied. This bandage might also be used to enclose only one breast. I will first

describe its mode of application when only one breast is affected, and when the sound one is left exposed for the nursing of the child. A roller three inches wide, and from ten to twelve yards long, is required. Both breasts are covered with absorbent cotton, and a small pad of cotton to protect the shoulders is in readiness. Beginning outside of, and below the affected breast, the bandage is carried twice around the chest, passing first across the front, then it is carried under the affected breast, over the opposite shoulder, and again around the chest, once more under the affected breast, and the second time over the shoulder. Then it passes again under the breast, the lower half of which is now nearly covered, and around the chest above the sound breast. The next turn comes directly over the nipple of the inflamed breast, and above the sound breast. Two or three more turns, then cover the remainder of the affected breast. If any bandage remains, a firmer support to the breast will be given by making a turn again under the breast and over the shoulder, and still another under the affected breast, and above the healthy one, finishing with an extra turn over both breasts. The bandage must then be well fastened with from twelve to twenty safety pins placed in front, at back, and at the sides. The cotton over the sound breast may be removed or an opening made to nurse the child.

When both breasts are to be enclosed, five or six yards more of bandage will be required. Begin with two turns around the body, and one turn under the first breast, and over the opposite shoulder as before. The bandage is then carried under the second breast, and over the back, across the shoulder opposite the second breast, down in front and under the breast again. Then it goes around the body, under the first breast, across the front part of the chest over the shoulder, under both breasts again and across the back, then over the shoulder opposite the second breast, and again under the second breast. This turn may be repeated the third time if necessary. Then the bandage is brought under the first breast, now nearly half covered, above the second breast, across the back, above the first breast and under the second breast, thus forming a figure of eight around the breasts. This may be repeated if necessary, and then the bandage is fastened with two turns of bandage around the chest over both breasts. This breast bandage must also be fastened with numerous pins. It is convenient to make the first turn with the patient on her back, and have her to sit while applying the rest. Much care should be taken in applying the bandage to make it just tight enough, and, on this account, the patient should be asked frequently if it is comfortable. If the bandage is too tight it may draw heavily upon the shoulders and become unbearable.

A very valuable adjuvant to the treatment of breast infection is the application of cold by means of the icebag. This not only has great

influence in relieving the pain, but also modifies favorably the infective process. It can be applied satisfactorily only when the patient remains in bed. It is indeed desirable that the patient should always keep in bed for at least two or three days. The ice-bag is used in connection with the Y or circular bandage. The thick layer of cotton with the roller bandage interferes with the action of the ice. The large-sized round bag is best. The ice should be broken quite fine, and the bag made to conform to the contour of the breast. If the infected lobe is on the outside, the bag is placed against the affected spot and supported by pillows or blankets. When the infected region is in the upper or inner side of the breast, the bag may be laid on the chest.

Under this plan of treatment we shall find, in almost every case, that the pain has largely disappeared in twenty-four hours, and at the end of from forty-eight to seventy-two hours that the local tenderness has disappeared, and the nipple is healed. The ice may now be removed and nursing resumed, the child allowed to stay at breast not more than four or five minutes. If nursing increases the pain it must of course be stopped for one or two days more.

If, in spite of this treatment, some tenderness continues or reappears after a few days, and if suspicion of fluctuation exists, with perhaps a slight increase in temperature, we must suspect the presence of pus. As was previously stated, this question can be easily and safely determined by the use of a proper hypodermic needle. If an abscess is present, however small, it should be opened at once. If we are in doubt as to the presence of an abscess, a continuance of the bandage support and the ice-bag can do no harm, and this is the best possible method of limiting the abscess formation and controlling the symptoms of pain and tenderness, until the diagnosis, and the need of an operation, can be definitely established.

Under the treatment of poultices, which was formerly so prevalent, it was frequently advised to allow the abscess to develop until a considerable portion of the breast was broken down before opening it. This unsurgical procedure resulted from the unfortunate experience that so many had had with the continued development of abscesses in the lobes surrounding those first attacked. The obstetrician could not assure his patient that one operation would be sufficient unless he waited until a very large abscess cavity was formed. The operation of opening an inflamed breast was very much dreaded; without an anæsthetic, it was very painful, and if an anæsthetic was used, a big operation requiring assistance was necessary. The method of infiltration anaesthesia has been of very great value to patients having abscesses of the breast, for by its use an abscess may be opened without pain, and so may be opened early. If a second or third abscess develops, it may

likewise be attended to with little trouble and expense. The manner of using the infiltration anæsthesia is very simple. After a careful disinfection of the skin a few drops of Schleich's solution No. 2, applied with any ordinary hypodermic syringe that has been rendered aseptic, makes the short line of incision anæsthetic. After the incision, the pus is washed out with sterilized water, and a few sterile or iodoform threads are introduced for drainage. A strict antiseptic dressing is applied, and the breast bandaged very firmly. In twenty-four hours the drainage is removed. The wound is kept open by irrigation for a day or two longer, when it will generally close of itself.

By this management we shall not see the extensive destruction of the breast, the long-continued suppuration, the fistulæ, eczematous skin, worn-out mother, and puny child. If we come across these neglected cases we must, of course, treat them according to the rules of surgical procedure which apply to such cases. These rules are too well known to require any further description.—*New York Medical Journal*.

SOME REMARKS ON A NEW METHOD OF TREATMENT OF ULCERS.

By C. A. PROTIN, M. D.,

NEW YORK CITY,

Late Assistant Physician to Bellevue, Northwestern, Columbus Hospitals.

So much has been written concerning the use of protargol in gonorrheal affections that I trust I may be pardoned for calling attention to a new use of this preparation. As a means of stimulating sluggish granulations nitrate of silver has always been a favorite application, and hence it occurred to me that protargol might have even a better effect owing to its strong penetrating power and because its application is unattended with any degree of pain or irritation. My expectations have been completely realized, and I have found the drug of great value in cases of varicose ulcers in drying up secretions, stimulating granulations, and exerting a disinfectant action. In traumatic ulcers it also proved an excellent cicatrizant and promoted rapid healing of the parts.

It was chiefly employed in the form of five or ten per cent. ointments with vaseline and lanoline spread on gauze, although it may also be used in solutions.

To demonstrate its action in cases of varicose and traumatic ulcers, I subjoin the following cases selected from my records.

Case I. Female, 45 years, had suffered for over twenty years with varicose ulcers on both legs, having been under treatment several times without any material benefit. She could not stop work, and did

not hope for a cure, but only relief from pain and itching. Ulcers were present on both legs, those on right one being the worst, and one ulcer being five inches in diameter. The surrounding skin was dry and scaly, and, as the patient states, very itchy. She complained of pain and heat owing to the warm weather. These ulcers were filled with pus, and the surrounding skin was irritated. Her general history was good. I placed her on iron, and used a carbolic wash for the ulcers and applied a wet dressing which was renewed every other day. On the fifth day I curetted the ulcers, and applied ichthyol and a balsam of Peru ointment, 10 per cent. This treatment was continued for four weeks without much progress. So I then determined to try protargol ointment, bandaging tightly as usual. There was continued improvement from the first day of this treatment, and in four months I discharged her cured, the ulcers having completely cicatrized. The relief from pain and inconvenience under the use of protargol was certainly remarkable, the patient continuing to work during the treatment. Three weeks later she met with an accident, and one of the ulcers reopened. I placed her on the same treatment, and in fifteen days discharged her, since which time, eight months ago, she has had no further trouble with her limbs, except slight stiffness. This is a remarkable result, considering the long duration of the trouble.

Case II. Male, aged 32, with a traumatic ulcer of the right leg, had been under treatment several times without permanent results. He had been suffering for four years, and gave no specific history. The ulcer was ugly and filled with pus; the surrounding parts red and irritated; the skin very dry and scaly. I applied wet dressings for several days and then ungt. ichthyol dressing every second day. At the end of three weeks, there being very little improvement, I changed the treatment to protargol ointment, 10 per cent., after curetting the ulcer, and in eight weeks obtained a complete cure. Since then he has had no further trouble with the limb.

Case III. Female, aged 35, varicose ulcers of the right leg of four month's duration. This leg was literally a mass of raw flesh. When I first saw her she could not sleep at night owing to the pain and itching in the limb. Wet dressings were applied for three days, using carbolic solution locally, and curetting the ulcers. I then used protargol ointment, 10 per cent. and tight bandaging. I dressed the limb every second day, and noticed improvement from the start, the exudation ceasing and granulating tissue springing up. In thirteen weeks she was cured, a new skin being thrown all over the limb, and at present she has only a slight stiffness in walking. She found immediate relief under this treatment, and has experienced no further trouble with the limb.

Case IV. Female, aged 30 years. Ulcers on the dorsal surface of the hand originally caused by a burn; duration three months. When I first saw the case the ulcer was filled with exudation. I applied wet dressings and used the curette, washing out with carbolic solution. The dressing was renewed every day until the pus formation ceased, and protargol ointment then applied, filling up the cavity with the ointment. The result was that in three weeks the cavity was covered with granulations, and since then I have heard nothing further of the case. I saw this case since. There is only a very slight scar.

Case V. Fireman, aged 33, while attending to duty at a fire, received a burn of the second degree on the left forearm. He was suffering great pain when I saw him. I made applications of wet dressings to the arm, and gave morphine sulphate, 1-8 grain. On the third visit I discontinued the wet dressings and substituted ungt. protargol, and in a few days granulating tissue began to form, and five weeks later I discharged the patient cured, with good movement of arm.

Besides its use in ulcerative conditions I would call attention to the efficiency of protargol in eczema, in which it also promises to be a valuable agent in selected cases, its effect here being to relieve pain and swelling and remove infiltrations.

Case VI. Male, 25 years of age, suffering from eczema of face and ears. The skin was badly broken in several places, and many vesicles and scabs present. I washed off the surface with boracic acid solution, and used ungt. zinc oxide for several weeks, and finding progress slow, tried various other agents. Finally a trial was made with protargol ungt. on thin gauze, first using ol. olivae generously all over the affected parts, and retaining the gauze in place with a face-mask. There was improvement from the first, and he was discharged in two months cured, with no recurrence up to date.

Case VII. Male, aged 20, suffering from ivy poison. The disease involved the whole left arm, the hand to the shoulder being badly swollen. The patient suffered severe pain. I decided to try protargol, first opening all the vesicles. The ointment was thickly applied on gauze, changing the dressing every second day. A cure occurred in seventeen days. There was a slight return of the eruption three weeks after on the front and back of the chest; the same ointment was again used with the same beneficial effect, and since then there has not been any recurrence (five months.)

In a case of eczema capitis, in which I tried all the remedies commonly employed without affecting the course of the disease in any way, I finally decided to use protargol, cutting the hair closely and washing with *sapo viridis*. In eighteen weeks the patient was cured, although the disease had been present six months before he came under my observation. I consider this a very good result.

GRIPPAL MEDICATION SIMPLIFIED.

The large and increasing number of deaths, especially among our prominent men, due primarily to the prevailing epidemic of LaGrippe, and the serious illness of President McKinley from the same cause, impresses us with the advisability of calling the attention of our many readers to the really excellent remedial qualities of the different products of The Antikamnia Chemical Company in the treatment of this scourge and its many insidious allied diseases. For the purpose of reference, we append a list of their various preparations, viz.:

Antikamnia Tablets.

Antikamnia & Codeine Tablets.

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Laxative Antikamnia Tablets.

Laxative Antikamnia & Quinine Tablets.

The last mentioned is a new and without doubt a most desirable combination in the above complaints and also in all malarial and congested conditions.

IMITATION THE BEST EVIDENCE OF THE VALUE OF THE ORIGINAL ARTICLE.

A preparation which has no value as a curative agent likewise has no sale: as a consequence it is not substituted. On the other hand as soon as any article through merit finds favor with the medical profession a host of imitators immediately spring up with the hope of securing business on the reputation made by the original preparation. At this time we wish to caution our readers that in prescribing Uterine Wafers Micajah's, the original, be specified. Don't simply specify Medicated Uterine Wafers, but avoid disappointment in results by writing Micajah's Medicated Uterine Wafers. In cases of Leucorrhea, Endometritis, Amonorrhea, Gonorrhea, etc., Micajah's Medicated Uterine Wafers are especially indicated. Their special form is a convenience for introduction and a decided advantage over other methods.

A VALUABLE HYPNOTIC.

Every progressive physician recognizes the necessity of overcoming the insomnia attending certain diseases. At this season of the year, when pneumonia is so prevalent, probably nothing will so satisfactorily relieve the distressing symptoms of sleeplessness as Bromidia. By the use of this reliable preparation we can obviate the effects of losing sleep, and at the same time feel that the heart's action is unimpaired, a dire calamity in a pneumonic process.—Vermont Medical Monthly.

Editorial.

JNO. C. LeGRAND, M. D.,..... Editor and Prop.

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THE ALABAMA MEDICAL JOURNAL, Birmingham, Ala.

A Bill

To be Entitled An Act to Make the Diploma of the Medical College of Alabama, Which is the Medical Department of the University of the State, Equivalent to a Certificate of Qualification to Practice Medicine, Pharmacy, or Dentistry in this State.

Be it enacted by the General Assembly of Alabama, that a diploma of graduation in Medicine, Pharmacy, or Dentistry, granted by the Medical College of Alabama, which is the Medical Department of the University of the State, shall constitute a certificate of qualification to practice medicine, pharmacy, or dentistry in this State: provided, that the Faculty of the said Medical Department of the University shall report to the State Boards of Examiners of Medicine, Pharmacy, and Dentistry, respectively, the names of all graduates of these several departments of their Institution, and shall also permit committees representing said Boards of Examiners to inspect the examination papers



of all applicants for graduation to be present at any oral examination that may be held for the same purpose.

The legislation proposed by the foregoing bill has elicited much comment and criticism both as to the purpose and effect of the movement. As a journal devoted chiefly to the promotion of the best interests of the medical profession, and as a matter of consequence to the welfare of the public health, it becomes our duty to further as far as we can those things plainly intended for the good of our profession, and likewise to firmly oppose all hurtful methods and unwholesome laws, which may in anyway apply to, or interfere with our present regulations as to the practice of medicine. The end contemplated by the bill is to admit to practice without the examination provided by statute, such as shall present a diploma or certificate of graduation from the Mobile Medical College. The wisdom of the present requirement has never been successfully questioned. The purpose of the examination provided by our statutes is to protect the profession against "quacks" and "adventurers," and to give the people educated, enlightened, and well equipped physicians. The examination fixes a safe standard and no one should be permitted to pass the entry portals of the profession without attaining that standard. An exception made in the interest of any College however competent and well qualified its graduates, and however extraordinarily the advantages it may afford, would inevitably result in the disintegration and final destruction of our present fairly well guarded system. An applicant for license to practice medicine in Alabama, who has graduated from a medical institution of respectable rank, and has shown such diligence and proficiency as to entitle him to honorable graduation, is well able to run the gauntlet; and on the other hand a graduate, from any school of medicine, for whom a universal standard has terror; to any great extent, ought not to be imposed on any community as the curer of physical ailments. The operation of every law is for good or ill. The statute pertinent to the present subject, and its original promoters are greatly valued by the profession and the people. The examination required is rightfully esteemed and considered as a strong bulwark builded and maintained for the public safety; and its setting aside for the benefit of any school or individual would eventuate in no general good, but in incalculable harm to our efficient and admirable system now in vogue.

Such an exemption as is sought in the legislation proposed, if enacted into a law, would not only be class legislation on its very face, but in its final effect would be merely an act for the relief of certain individuals, and would be to that extent a violation of one of the most righteous principles of government, "Equal rights to all and special privileges to none."

Annual Banquet.

The annual banquet of the Jefferson County Medical Society was held Dec. 28, 1900, 8 to 12 p. m., occurring at the Arlington, where C. H. Nabb spread the table the entire length of the cafe and served an elegant menu in courses, with cigars and sauterne wine on the side.

The table contained a tall vase of red carnations in the center and white jonquills were on the wings in each direction. There were eighty guests at the feast, a number of outsiders being privileged to the good things served and heard.

Dr. W. E. B. Davis, the new President of the association, presided at the head of the table, with Dr. E. H. Sholl, the nestor of the profession in Birmingham, at the opposite end. During the course of the evening Dr. Wyatt Heflin assisted as toastmaster and added much to the mirth of the gathering with his ready and droll wit. Dr. Davis made a capital toastmaster.

Dr. R. M. Cunningham responded to the toast, "The Medical Association of Alabama," saying many wise things in a very eloquent manner. He entered a protest against the proposition, which he stated that he had heard would be brought before the General Assembly, to grant licenses to graduates of certain institutions to practice medicine without passing the usual State and county examinations. He stands for the present high standard of the profession maintained in Alabama.

The toastmaster gave a brief epitome of the history of medicine in Jefferson county from 1819 to 1883. The Jefferson County Medical Society, he said, was organized in 1865, with Dr. Frank Prince as President and Dr. Joseph Hawkins as Secretary. Of the early physicians in the county, among the most celebrated were Dr. Joseph R. Smith, Dr. Daniel Davis, Dr. Samuel Earle and others. As illustrious physicians who had shed honor on the profession in the past, he named Drs. Jordan, Luckie, Sears and Taylor. The society is now the largest in the State, with 100 members.

Dr. Davis then called on Dr. E. H. Sholl, who spoke of the county society from 1883 to the present time. In 1883 the society had thirty-one members, of whom eight are dead, twelve are still in Birmingham and ten have moved away. Among those still here are Drs. Sholl, Abernathy, Copeland, John Davis, Douglass, Henley, Ledbetter, Luckie, Prince, McCarty, Robertson, Rosser. The speaker was glad to state that as able physicians as are in the country are located in Birmingham. In particular Dr. Sholl contended that there was no cause to send for outside physicians or carry patients to hospitals or infirmaries elsewhere, as any known operation in the world or the latest treatment can be given here as well. He stood for home talent, and he believed that when a local physician came across something not in his particu-

lar line he should call in some local physician who was an adept in that department.

Dr. E. P. Riggs paid an eloquent tribute to St. Vincent's Hospital and expressed his earnest desire that the Hillman Hospital management would yet realize their desire to do good.

Prof. J. B. Cunningham spoke in advocacy of a high degree of general culture for the professional man. He said the day of the self-made man was past and that even the successful self-made man would be more successful with greater culture as a foundation.

Dr. B. L. Wyman responded to the toast, "Medical Education." He called attention to the higher standards of the present day. He believed, however, that the only feasible plan for establishing and maintaining the perfect medical college with the proper accessories was by endowment. He believed in maintaining the high standard set by the local physicians and the local medical college, of which he is the dean.

Dr. Wyatt Heflin said many witty things in the course of a talk on "The Bachelor Physician and How to Get Rid of Him." Dr. Heflin made the table roar several times with his inimitable imitation of quaint and curious characters.

Dr. J. C. LeGrande, editor of the Medical Journal of Alabama, made an eloquent speech, in the course of which he pointed out the conspicuous work for the profession done by the medical journals and the power of the medical as well as the secular press. He made a strong plea in favor of the State Medical Association and its high standard, and encouraged the younger members of the profession to become its most honored members. The address was roundly applauded.

Mr. Richard F. Johnston, of the News, responded for the secular press. He complimented the physicians of Jefferson county upon the high tone maintained by them both as practitioners and as citizens.

Dr. George S. Brown was called upon to respond to the toast "The Ladies," and recited a dainty poem suitable to the subject. Dr. G. C. Chapman took up the toast and expressed his regret at still being in the ranks of the single.

Colonel L. W. Johns, of Sayreton, made a splendid talk on the resources of the Birmingham district, which he has for twenty years helped develop.

* * * * *

Mr. Tyler and Dr. Collins made short talks.

Dr. Cunningham Wilson, Dr. Douglass, Dr. Black and others closed the evening with bon mots. Dr. Black was urged to sing a song, which he gracefully declined. Dr. Heflin wound up the wit and wisdom of the evening with an imitation of exercises in an Arkadelphia,

Blount county, singing school, which provoked great laughter, and a delightful evening was at an end.

The banquet was a delicious flow of good things of many sorts—the best in fact the local society has ever had.—Johnston in News, Dec. 29, 1900.

The Tennessee Valley Medical Association.

This association was organized on Dec. 19, 1900, in the city of Huntsville, Ala. The association is to be composed of the physicians of the counties of Colbert, Jackson, Lauderdale, Lawrence, Limestone, Madison, Morgan and Marshall.

The following officers were elected: President, F. E. Baldrige, Huntsville, Ala.; First Vice President, T. A. Casey, Albertville, Ala.; Second Vice President, F. P. Petty, Decatur, Ala.; Secretary, T. E. Dryer, Huntsville, Ala.; Treasurer, Edgar Rand, Huntsville, Ala.

Advisory Board: Five years, J. L. Darwin, Huntsville, Ala.; four years, J. P. Rorex, Scottsboro, Ala.; three years, W. C. Wheeler, Huntsville, Ala.; two years, J. T. Masterson, Moulton, Ala.; one year, J. C. Rankin, Belle Minor, Ala.

Speaking of the first meeting the Secretary says: We expect to make a good society of this and feel very much encouraged as we organized with membership of 47. The association will meet in Decatur the second Tuesday in February. We are to have three meetings a year, as follows: February, June and October. We enjoyed ourselves very much at this meeting.

THE PREDATORY MOSQUITO.

Every physician who "keeps tab" on the advances and discoveries of medical science is now aware that there are two kinds of mosquitoes—the good and the bad. We presume, however, that some one will dispute this statement, and say of this insect as the average army officer says of the Indian, "There's no good mosquito but a dead mosquito."

It's true that they all sting, but some of them add insult to injury by injecting the malarial virus into her unsuspecting victim. We say her, because we believe the male mosquito is a better-behaved insect than his spouse and does not "present his little bill" at inconvenient times.

These few remarks are but prefatory to the announcement that The Palisade Manufacturing Co. has prepared and is now mailing to physicians an illustrated folder, showing in sepia the distinctive differences between *Culex* (the non-malarial) and *Anopheles* (the malarial) mosquito, with instructions as to how to detect the good insect from the bad. A copy will be mailed to any physician who has not as yet received one.



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By being prescribed by the leading physicians of all schools for the leading women of all classes. Where immediate and harmless effects are desired, in either primary or chronic discharges from the vagina. In promptness and harmlessness nothing equals

TYREE'S POWDER.

Its effects are the same when engaged in social festivities as when reclining in bed, because it is quick to act, slow to harm and simple to use. No corrosion, smarting or puffiness of parts, nothing to grease, stain or smell. Simply a pleasant soluble powder, which when added to water and used as a douche or in the bath, checks odors and discharges of all kinds and produces a feeling of absolute cleanliness and refreshness at an expense of about 2c. Enough to substantiate these claims will be sent *once only* for 10c.

WAR DEPARTMENT.

SCURFON-GENERAL'S OFFICE, WASHINGTON, D. C.
"The exact antiseptic strength of Tyree's Pulv. Antiseptic Comp. is one part of the powder to fifty of water (1-50)." W. M. GRAY, M. D.,
Microscopist to the Army Medical Museum.

"An excellent preparation and purely antiseptic."—DR. S. HEMMINGWAY, Blackwell's Island Hospital, N. Y.

"A preparation of unquestionable merit."—*Maryland Medical Journal*.

"I find it of very great value."—DR. G. F. HULBERT, Woman's Hospital, St. Louis, Mo.

"I employ a solution of Tyree's Antiseptic Powder, which consists of, parts, Sod. Bor. 50, Alumen 50, Ac. Carbol. 5, Glycerin 5, the crust principles of Thyme 5, Eucalyptus 5, Gaultheria 5, and Mentha 5."—DR. LEWELLYN, Surgeon to Providence Hospital, Eastern Dispensary, and Pres. Med. Assn. of the District of Columbia.

COLUMBIA MATERNITY HOSPITAL,

WASHINGTON, D. C.

J. Wesley Boyce, M. D., Gynecologist to Columbia and Providence Hospitals, and Clinical Professor of Gynecology in Columbian University, Washington, D. C., says: "The sample of Tyree's Antiseptic Powder sent to Columbia Hospital for Women for my use has given most excellent satisfaction. In Vaginitis and relaxed vaginal walls as well as some forms of inflammation of the Neck of the Uterus, I have found it unusually beneficial."

OLD MARION STREET MATERNITY HOSPITAL.

W. BALDWIN WAYT, M. D., MED. SUPT.

The results obtained from your "Antiseptic Powder" were most satisfactory, being used in cases of Gonorrhea and Leucorrhea, and results obtained were most pleasing, relieving the symptoms in both cases. With best wishes,

Very truly,

W. BALDWIN WAYT.

J. S. Tyree, Chemist, Washington, D. C.

Miscellaneous Notes.

The readers of the Journal are requested to note the new advertisements in this issue.

We again call attention to the fact that we will be pleased to have papers read before the different medical societies for publication in the Journal.

F. E. Harrison, M. D., Abbeville, S. C., says: I have used Celerina in appropriate cases, and can heartily recommend it to all who wish an elegant preparation, combined with undiminished therapeutic activity. It is peculiarly fitted to such cases as delirium tremens, headache from debauch or excessive mental or physical exertion.

The attention of our readers is called to the advertisement of Robinson-Pettet Company, which appears in this issue.

This house is one of long standing, and enjoys a reputation of the highest character.

The preparations referred to, we commend specially to the notice of Practitioners.

Remittances have been larger this month and renewals greater on the subscription list to this Journal than any month in the Journal's history. Most of these came from the doctors in small towns and the country places in the State of Ala. Two dollars may seem to be a very insignificant sum, but when a large number of doctors send in \$2.00 on subscription it is a wonderful help in paying expense accounts.

FUNDAMENTAL PATHOLOGICAL ULTIMATES.

As a foundation for rationale therapy in gout and rheumatism it must be borne in mind that in these disturbances we have to deal with a faulty condition of metabolism as the underlying cause, and symptoms vary as to the tissue or organ affected; defective elimination is an important factor in both; the skin, digestive organs and kidneys being at fault. These ultimate facts can be controlled by the mixed treatment suggested in the formula of Tri-Iodides, Henry, which contain all the constituents required as an eliminant.—Medical Essays.

THE RADICAL CURE OF INGUINAL HERNIA IN THE FEMALE.

By Dr. William B. Coley. While most authorities agree that inguinal herniæ in women and children are more amenable to cure by mechanical treatment, the author's experience has led him to believe

that the difference is very slight. As to the opinion of Kelly, that removal of the sac is of little importance, the author believes such an opinion erroneous. The transplantation of the round ligament is never indicated. In the author's cases—one hundred and twenty-three in number—the method employed was Bassini's, the single step of transplanting the cord being omitted. Rubber gloves are advocated by the author, and in support he cites the bacteriological findings in thirty-five examinations of the nails and hands of surgeons. Of sixty-eight cases in which portions of the skin were removed from the field of operation just before the primary incision was made, fifty-three were found to be sterile. Chromicized catgut or tendon may be rendered perfectly sterile, and the author prefers it to silk, silver wire, or silkworm gut. In the operation itself the cutting of the internal oblique muscle is not only unnecessary, but likely to weaken the canal. There has been no mortality in the author's cases. Seventy-three patients were under fourteen years of age, and fifty were between fourteen and seventy years. In eight cases suppuration occurred, limited to stitch-hole infection. The average time in bed was eight days, departure for home was permitted in two weeks, and a spica bandage was kept on for two weeks longer. Not a single relapse has been observed. The prognosis, from these notes, would seem to be better in the female than in the male. In 545 cases of inguinal hernia in the male, operated upon after Bassini's method by the author, there have been six relapses. —New York Medical Journal.

RECURRING PAROTITIS.

Dr. Fayette C. Ewing (*Annals of Otology, Rhinology and Laryngology*, August) reports a case of recurring parotitis in an otherwise healthy child eight years old, the son of the writer. The boy has had the attacks since his second year, occurring at irregular intervals. He has never been especially subject to colds nor shown the catarrhal diathesis. Family history good. The attacks are attended with pain on pressure and mastication, but never intensely acute. No attendant enlargement of the lymphatics, nor the slightest hypertrophy in the parotid after the subsidence of the acute symptoms, which have generally disappeared without any special treatment within three or four days. No fever, and little constitutional disturbance. The swellings have, with one exception, been unilateral, and have developed suddenly, often manifesting themselves during the night. They have apparently diminished in frequency as the child has grown older.

The doctor considers the case to be due to a patulous condition of Steno's duct, allowing of infection to the parotid from the mouth. As the disease has never in this case gone on to suppuration, the microbic

infection is not severe, and probably originates in some of the numerous bacilli always present even in healthy oral cavities. The case is interesting from its rarity, and also as proving the assertion of Reguier, surgeon to the Laribiosiere (*Journ. de Medicine*, Ed. de Paris, Jan. 1, 1896), that parotid inflammation is not invariably caused or accompanied by lymphatic gland involvement elsewhere, but may occur through the excretory duct of the parotid itself.

CONCERNING CORSET LIVER.

By Dr. G. A. Leventhal.

The author gives a comprehensive review of the subject of corset liver and reports a case in which corset pressure produced a very pronounced lobulation of the liver, giving rise to a tumor in the abdomen. A pronounced corset liver occurs, according to Leue, who examined 3,184 cadavers of persons over sixteen years of age, in 25.3 per cent. of women and in 1.9 percent. of men. Quinke gives the percentage of corset livers in women as 56.3 per cent., in men as 5.7 per cent., but his figures include cases in which there is only a furrow in the liver substance due to tight lacing, in addition to those in which there is pronounced corset liver.

The term "corset liver" is not exact, for furrows may be the result of tight lacing without corset, e. g., by any form of belts, petticoat-strings, or other constrictions about the waist. The author agrees with Langenbuch and Thiersch that a corset which is not tightly laced rather protects the abdominal organs from the still more injurious effect of the tight waistbands. The latter are especially injurious in cold weather when the weight of heavy skirts is added to the compression. In these cases the corset becomes a point d'appui which supports the weight of the heavy clothing. The author analyzes the classification of corset liver as adopted by Hayem, by Quinke, and other authorities, and reports the case of a Russian peasant woman, aged twenty-seven years, who gave the following history: She lived in the country until her seventh year, then in Moscow. Until her fifteenth year she wore a waist with whalebone supports; after fifteen and until twenty years of age, the long corset. She rarely laced excessively. When she became pregnant for the first time seven years ago she substituted tightly drawn waistbands for the corset, and resumed the corset after labor. She entered the hospital complaining of severe cough, dyspnoea, weakness, and vertigo. On examination she was found to be a poorly nourished woman with a thorax paralyticus, i. e., an evenly constricted lower portion of the chest (Quinke). Tuberculosis of the right apex, Koch's bacilli in the sputum. The right upper portion of the abdomen was more prominent than the left, and

palpation in this region revealed a smooth, hard, triangular tumor which disappeared into the hypochondrium. The lower edge of the tumor was sharp and movable upward, but no sulcus could be distinguished. The liver dulness was continuous with that of the tumor. The diagnosis of corset liver was made by excluding all other causes of liver tumors. In moderate cases of corset liver no treatment is necessary. If perihepatitis, chronic congestion, or complicating affections of the gall-bladder or ducts occur, as they frequently do, the condition present must be treated. Landau recommends the wearing of elastic abdominal belts, but Langenbuch does not think this measure effective. Good results have been obtained by Billroth and Tscherning (Czerny?) by ventrofixation of the floating lobe. Resection of this lobe has been successfully performed by Langenbuch. The chief point is prophylaxis—reform of woman's dress.—New York Medical College.

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FEEDING OF INFANTS.

By J. Farrar Haley, M. D., Oenaville, Texas.

The subject in question is one too broad, too profound, too exhaustive, for me to satisfactorily treat in this limited paper. I will endeavor to call to your attention the more salient points and leave to your discussion the subject in its completeness. We believe that there is no branch of our profession of more importance or as difficult of understanding, more important because of tenderness of age of patient under treatment, and less understood, as shown by the high mortality at this age. The death rate of infants from diseases incident to the alimentary canal is truly appalling, and since this condition depends largely upon dietary we conceive at a glance the prominence of the subject. If we in every instance could furnish the ideal food we would meet the panacea to the prevention of these dread diseases. Observation, as well as experience, has proven that the welfare, the health, and the growth of the infant depends not so much

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on medicine as proper care and feeding. We believe that if a strict and proper diet sustained in every instance, infantile mortality would be reduced 90 per cent. If these opinions are true, our profession is alarmingly ignorant or negligent of its duty in the premises. We concede, however, that in many cases the physician is not responsible for these results. Often, and most often as for that, he has no knowledge of condition of infant or its mode of life until it is in the clutches of some dread disease. Then, when sent for, he must play the role of an instructor, a lecturer, and proceed to enlighten the mother, the aunt, the grandmother, of the little 'unfortunate—a most difficult task.

Concerning the infant's nourishment, let our ideal be nature's ideal—the mother's milk, and this our guide around which all other foods revolve in seeking perfection; remembering, however, that mother's milk is the ideal to the extent that we are furnished the healthy milk from healthy mothers.

Many mothers are not healthy, and even if they are they often give poor milk. These are points of interest, and require careful study, since the health and welfare, and even the very existence of the little one depend upon them.

To improve conditions of mother and quality of her milk we look to tonics and regulation of her life and habits. If she be constipated, anemic or nervous these impressions are transmitted to the infant, and he suffers the consequences. If constipation the fault, relieve by exercise, habit and proper medicine; if nervous exhaustion, rely on nerve tonics and rest; if anemia is of the kind that can be relieved do so; if permanent and of a serious constitutional character, withdraw the infant at once from the breast and depend entirely upon the "bottle."

With reference to the quality of milk the question naturally arises at this stage what are the constituents and their proportions of good healthy mother's milk, and what the amount of such food required by the average infant that he may thrive best? Proper and careful analysis have shown that infants to do best should receive milk which contains fats, proteids, sugar and salts in following proportions, respectively: 4, 1 1-2, 7 and 2 per cent. These investigations may be sufficiently accurate to be remembered, and any great variation therefrom may be viewed with suspicion. While the quality remains practically constant, the quantity varies with age of infant. The average healthy child receives during the second and third week of life approximately 20 ounces of milk per diem; at twelve to sixteen weeks, 1 quart, and a continued increase with the age until at one year he consumes between 40 and 50 ounces of milk every twenty-four hours. Regularity of feeding, length of time at the breast, and amount fed at each nursing are considerations well worth remembering.

The nursing children are not the ones, however, about whom we are mostly concerned; if so, the solution of this problem would be comparatively nil. His more unfortunate brother—the one for whom nature has failed to provide—is he who demands our attention and profound consideration. This age of inherited weakness, depraved nature, and growing pathogenic tendencies calls for wakefulness, watchfulness and alertness on our part.

No branch or subdivision of medicine gives us more concern than artificial feeding. And here we might give our opinion concerning the employment of wet nurses. I have my serious doubt as to the propriety of ever relying upon this means of feeding. When we remember the class of individuals from whom we are to select, and when we remember how readily constitutional diseases are transmitted through the breast, and when our attention is further called to the fact that the expense of employing a wet nurse reaches far beyond the financial strength of most people, we think it wise to abandon this method altogether, and rely upon our skill to prepare properly other foods.

The best, and without doubt the most convenient, of the artificial foods is the cow's milk. It contains essentially the same ingredients as the mother's, but in different strength. To convert this into acceptable nourishment much preparation is required. We must select the healthiest cows fed on the best and purest food. Use rather the milk of a herd than that of a single animal. Other considerations are the age of the food, its cleanliness, and its strength. These are of paramount importance, since bacteria increases with age of milk, and since these pathological conditions depend directly upon these poisonous germs.

This matter is of more import in cities than in small villages and in rural districts. The milk here is often forty-eight to sixty-four hours old before being used. What, then, is the best method of preparing this milk for long continued use?

After the age of eight, ten or twelve hours it will not bear being fed plain. It is claimed that heating milk to the point of 167° F., known as pasturization, sufficiently sterilizes it to destroy typhoid, diphtheria, tubercular and scarlet fever germs, and at the same time does not alter the taste or the digestible quality of the food. If these investigations are true, and we accept them as such, this is better than subjecting it to a higher temperature. This we believe to be the best means of preserving milk for short periods of time. While for traveling long distances, sea voyages, etc., in way of convenience, condensed milk is best. The preparations of this we are all more or less familiar. It consists of heating fresh cow's milk to a temperature of

212° F. for a stated time, then evaporating in vacuo at a low temperature and adding cane sugar. This is conveniently kept in tin cans. When fed we add ten or twelve parts of sterilized water to one part of milk. This reduces the per cent. of casein until it is easily assimilated by the most delicate stomach.

In studying the subject of cow's milk for infant feeding we should examine it from every point of view, even to the selection of the dairyman and his herd. Call this party's attention to his responsibility in the premises. The more nearly immaculate he can present himself, his herd and their compartments the more fortunate for all concerned. The physician can do much to encourage him in this respect. If practicable, organize a board of health. Have the milk examined as to cleanliness, strength and age, and refuse to tender your approval or endorsement until these requirements have been scrupulously complied with.

As to the so-called prepared foods that flood the market, notably Nestle's Food, the malted foods, the farinaceous foods, these cannot be too strongly condemned. They all contain one of the cereals, and are hard to digest. It is a notable fact that when they are given for a long time they invariably develop in infants either scurvy or rickets, two of the most unfortunate conditions of childhood.

In selecting food in case of sickness the same rules apply as in health. However, a reduction in quantity is required, and its solution is essential. Give abundance of water, much less food, and increase the intervals between feeds. As the child almost invariably suffers with a delicate and weak digestion at this time, we often aid assimilation by giving pepsin or hydrochloric acid after meal. Or, probably, a preferable method would be to partially or completely peptonize the milk by addition of extract of pancreatine and bicarbonate sodium. This prescription is carefully prepared, placed in glass tubes of convenient size, and has proven eminently satisfactory to all by whom employed.—Texas Medical News.

TUFF'S COLLEGE MEDICAL SCHOOL—DEPARTMENT OF CHEMISTRY.

Boston, Mass., Nov. 20, 1900.

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Gentlemen:—A sample of "Pil. Quin. Dad," bought in the open market and examined by me, showed a state of purity unexcelled by the products of other houses. As far as the perfect solubility in definite amounts of ether, water, alcohol and chloroform, behavior to nitric, sulphuric acids and ammonia, absence of free acid, freedom from

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Gentlemen—Your sample of Auto Toxide received, and commenced testing it for Flatulent Dyspepsia, the result of a heavy supper. The distress following a ravenous appetite never occurs and the patient can now enjoy a heavy meal with perfect impunity. One to two tablets will relieve a flatulent condition in 15 to 20 minutes without fail. This is my experience with many patients. Will have my druggist order a supply as Auto Toxide is the medicine par-excellence for the condition above described.

Yours truly,

A. V. Robie, M. D.

Black River Falls, Wis.

PHYSICIAN CARELESSLY ACCELERATING DEATH.

When the case of Gray vs. Little was before the Supreme Court of North Carolina for the first time it held erroneous, as stated on page 162 of *The Journal A. M. A.*, of July 21, 1900, an instruction to the effect that only nominal damages could be recovered for a death where it was only accelerated by the malpractice and negligence of the defendant. But it was sheer inadvertence on its part, it says, on the re-appearance of the case before it, that it then referred to an instruction that was asked and not given in a way which led the lower court on the second trial to submit an issue as to punitive damages. The State statute which authorizes the recovery of such damages as are a fair and just compensation for the pecuniary loss resulting from a wrongful killing, which confers the right to recover in such cases, it holds, restricts the recovery to compensatory damages. But it says that it is difficult for it to comprehend how the jury could have returned a verdict of \$100 as compensation for the death by malpractice, as was found, of a wife and mother 33 years of age, and it suggests that considerations of humanity would seem to require that the case should be investigated by the solicitor for the district, if the criminal arm of the law has not already been invoked.—*Journal of American Medical Association*,

OBSERVATIONS ON THE OBSTETRIC SURGERY OF PELVIC CONTRACTION.

By Dr. Charles Jewett.

The opinion seems to be that pelvic contraction is very rare in this country. The author believes, however, that the frequency of this anomaly does not differ materially from that in the old world. It is present in from 10 to 15 per cent. of all parturients. There is urgent need of more systematic pelvimetry in our hospitals and in general practice. The minutiae of pelvimetry are considered. Among the more useful indications of pelvic contraction at labor are the following: (1) Failure of the head to engage during active labor. (2) Failure to engage the head by well-directed suprapubic pressure. This is a diagnostic point which may often be employed to advantage in the few weeks immediately preceding labor. (3) Failure of tentative traction with forceps. In partial engagement of the head, the latter should always be tried with the aid of the Walcher posture before resort to cutting operations. The methods of delivery in pelvic contractions, are (1) spontaneous delivery; (2) craniotomy; (3) the induction of premature labor; (4) symphysiotomy; (5) Cæsarean section. Each of these subjects is discussed in the article, and the usual textbook comments are made thereon.—New York Medical Journal.

NOTE ON A CASE OF PROTRACTED STUPOR OR TRANCE.

By Dr. D. Drummond.

The author reports the case of a man, aged twenty-six years, who when first seen, was in a state of trance, or stupor. He had always been melancholic and fanatic on the subject of religion. For a year past, he had lost his appetite and was thin and pale. In March he had a "fit," from which he passed into a state of lethargy. He had not moved or spoken for a week, but lay motionless, his eyes being open and staring, limbs cold, flaccid and unresisting. The reflexes were just perceptible, with the exception of a corneal reflex, which was active. There was involuntary defæcation and micturition. He slept well, but could be aroused without difficulty. He was fed with milk, beef tea, and eggs, from a feeding cup through a short rubber tube. The strongest faradaic current produced no response. Pulse 100. Temp. 97° F. In May, he developed dry cough, due to plugging of the left bronchus with food. At the end of seven months, he began to improve very slowly, and is now almost well. The case differs somewhat from both anergic and melancholic stupor; from the first, in that consciousness and memory were not entirely in abeyance; and from the second, in that the muscles were flaccid and absolutely unresistant.—New York Medical Journal.



A TEXT-BOOK UPON THE PATHOGENIC BACTERIA. For Students and Physicians. By Joseph McFarland, M. D., Professor of Pathology in the Medico-Chirurgical College, Philadelphia, etc. With 142 Illustrations. Third Edition, Revised and Enlarged. Philadelphia: W. B. Saunders & Company, 1900. Price \$3.25 net.

Prof. McFarland brings to us a book fully up to date on bacteriology. It is true this subject has been ably discussed by many and well known writers, but for medical students the book before us contains many important features, which will at once be appreciated.

THE NEW STANDARD—THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. For Practitioners and Students. A Complete Dictionary of the Terms Used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, and the Kindred Branches. With New and Elaborate Tables of Arteries, Muscles, Nerves, Veins, etc.; of Bacilli, Bacteria, Micrococci, etc.; Eponymic Tables of Diseases, Operations, Signs and Symptoms, Stains, Tests, Methods of Treatment, etc. With numerous handsome illustrations and 24 colored plates. By W. A. N. Dorland, A. M., M. D., Assistant Obstetrician to the University of Pennsylvania Hospital; Editor of "The American Pocket Medical Dictionary." Handsome large octavo, nearly 800 pages, bound in full flexible leather. Price \$4.50 net; with thumb index, \$5.00 net. Sent postpaid on receipt of price. W. B. Saunders & Co., 925 Walnut St., Philadelphia, publishers, 1900.

We have been called upon to review a number of dictionaries during the last two years, but have carefully reached the conclusion that the one before us is decidedly the best dictionary yet published. It contains many new and important features not to be found in any other work of the kind. It is well bound and printed on the very best paper and in good, clear type. There are over 100 tables, bringing out beautifully and clearly new tables of stain and staining methods. The illustrations and colored plates are numerous, all of which have been specially made for this work, including a large number of new colored plates of Arteries, Muscles, Nerves, Veins, Bacteria, Blood, etc. The

physician or student in need of a Dictionary will find this the very best yet published.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE. By James M. Anders, M. D., LL. D., Professor of the Practice of Medicine and of Clinical Medicine in the Medico-Chirurgical College, Philadelphia; Attending Physician to the Medico-Chirurgical and Samaritan Hospital, etc., etc. 8vo, cloth, pp. 1292. Illustrated, 4th edition, thoroughly revised. Price, cloth \$5.50, sheep and half-morocco \$6.50 net. W. B. Saunders & Co., Philadelphia and London, publishers, 1900.

The books on the practice of medicine are numerous, and sometimes it grows impatient because so many books are presented on the subject, and differ only in the manner in which they may be brought out, and the special characteristics of the writer, or this or that author's way of expressing the same idea. But this book brings with it a new impetus to see what it contains, and as we read its pages much information is gathered and many helps which are invaluable are to be found. The 4th edition of this superior work is on our table, and the fact that the previous issues or editions have been so readily sold indicates the preference on the part of the profession for Anders' work. The book has been adopted by a number of colleges as a text-book, and the 4th edition is more valuable than its predecessor in that it contains an addition of a chapter on diseases of the digestive organs, and on those of ileocolitis in children, and acute cholecystics.

PHYSICIANS' MANUAL OF THERAPEUTICS. Referring Especially to the Products of the Pharmaceutical and Biological Laboratories of Parke, Davis & Co. Flexible morocco; 12 mo; pp. 526, Detroit, 1900.

In his preface to this excellent little book, the author says: "There has been much well-meaning derision of 'elegant pharmacy,' but we do not sympathize with it; and the products enumerated in this volume are deliberately made as sightly, palatable and inviting as possible without sacrificing any of that therapeutic efficacy which is the supreme end of medication." That sentence contains, as in a nutshell, the whole secret of the great success of Messrs. Parke, Davis & Co. While their pharmaceutical preparations are elegant, they are honest, and always up to the required standards of medicinal strength. The Physicians' Manual has evidently been brought forth under the same conditions. It has a handsome cover, it is durably bound, and an examination of its pages discloses the fact that it is full of "meat." We admire the scientific tone which is evident in each section of the book.

Part one is entitled "Therapeutic Suggestions," and, as its title

indicates, comprises various useful hints on the prophylaxis and treatment of diseases, the names of which appear in alphabetical order, as sub-heads. A number of useful tables have been arranged to assist the inquirer in the differential diagnosis of the exanthemata, the calculation of metric values, thermometric equivalents, etc. The body of the book is given over to the department of "Materia Medica," which is, in brief, an alphabetic catalogue of drugs and seems to be thoroughly complete and up-to-date. No secret preparations are mentioned nor is mention made of antiquated or absolute remedies. The various preparations of the different drugs, such as pills, tablets, capsules, elixirs, are alphabetically listed under their respective heads and may be found without confusion or delay. The printer and bookbinder have done their work well and there is no doubt that the demand for this excellent "Manual" will more than compensate the publishers for what must have been a considerable outlay of time, effort and money.

INTERNATIONAL CLINICS. A Quarterly of Clinical Lectures and Especially Prepared Articles on Medicine, Neurology, Surgery, Therapeutics, Obstetrics, Pediatrics, Pathology, Dermatology, Diseases of the Ear, Eye, Nose and Throat, and other Topics of Interest to Practitioner and Student. Edited by Henry W. Cattell, A. M., M. D., Philadelphia, with Collaboration of John B. Murphy, Alexander D. Blackader, H. C. Wood, T. M. Rotch, E. Landolt, Thomas G. Morton and Charles H. Reed. Vol. III. Tenth Series, 1900. J. B. Lippincott Company, 1900.

In volume three of the tenth series of the Clinics we find a large list of Contributors which will at once specially interest the reader with the value of the volume. Drs. Valentine, Bulkley, Lewis, Reed, Whittaker, Lillunthal, Morris, Myer, Rodeman are among those whose writings make this an exceedingly valuable book. Many physicians look with interest for the "Clinics" because so much valuable and reliable information is given. The average, busy practitioner has learned to rely on these books as containing the most recent and best thought on every subject treated. The volume before us is one of the very best yet published.

A TEXT-BOOK OF THE DISEASES OF WOMEN. By Henry J. Garrigues, A. M., M. D., Gynecologist to St. Mark's Hospital in New York City; Gynecologist to the German Dispensary in the City of New York; Consulting Obstetric Surgeon to the New York Maternity Hospital, etc., etc. With 367 Illustrations, (3d) Edition, thoroughly revised. Price, cloth, \$4.50; net; sheep or one-half morocco, \$5.00, net. W. B. Saunders & Company, Philadelphia.

In this day when so many books of merit are being written and

published, we are likely to become weary of perusing and studying the many valuable helps given in the average book on the subject. The author of this book has evidently given much time and study to those important practical points, which are so essentially necessary to be understood by the student, and the fact that there is found to be a demand for the 3d Edition is beyond question a guarantee that Dr. Garrigues has given the profession a work which they appreciate, and it has shown its appreciation by accepting it as one of the best publications on the diseases of women. The present edition has been thoroughly revised and is not only practical and easy of comprehension, but it is clear and scientific in its technical teaching. The practitioner, the student and the teacher in the Medical College will alike find this work up to date and especially suited to all modern demands.

The Mosquito and Malaria.

The most recent researches into the life-history of the parasite which is the cause of malaria show, apparently beyond all reasonable doubt, that not alone is infection due to the bite of the mosquito, but that the disease cannot be contracted in any other manner. This is a great step in advance, because it enables those searching for means of general prophylaxis to concentrate their efforts upon a single goal—the extermination of the offending species of mosquito, or the effective protection of man against its bites.

Those who think that this statement of the role played by the mosquito in producing malarial infection is extraordinary should not forget that the instance is by no means an isolated one in biology. Texas fever, which at times seriously affects the cattle of our southwestern plains, and which is marked by fever and succeeding anemia and loss of flesh, is an instance exactly in point. It has been positively shown that the blood of cattle ill with this disease contains, in the red blood-cells especially, a hemosporidium whose behavior is in every way similar to that which in man causes malaria. It has further been found that the cattle are infected with this organism by the bites of a tick that inhabits their hair. Cattle whose hide is kept free from this tick do not get the fever, even when living along with those that are infected. It has been found that the pathogenic hemosporidium passes through one of its two life-cycles in the intestine of the tick. And so in the case of the plasmodium that causes malaria in man, it is necessary that it pass through one of its life-cycles in the intestine of the mosquito before it is prepared to infect the human being with malaria, unless indeed direct inoculation of infected blood into the healthy subject be practiced, when a positive result is practically always obtained. —Cleveland Journal of Medicine.

Abstracts.

Some Legal Points in Medical Punishment.

(Address before the Toledo University Club by B. Becker, M. D., Toledo, Ohio.)

If, during the trial of a delinquent, it is found that he was under mental restraint and legal disability, he will not be punished. Or if a mentally diseased person sells property and signs a deed, the action will be annulled, if it can be proven that the person was under a mental restraint at the critical time. In short, every act and deed of a mentally defective individual loses its legal validity. Therefore the court has the power to deprive such a person of the right to commit acts and deeds to which every moral individual of age is entitled. In such cases the competent court will give its verdict as soon as it can be convinced of the existence of a legal disability. To this end it requires the testimony of medical experts. The task for the medical expert is by no means an easy one in these cases. That it is especially complicated and difficult may be better understood if we keep the following cardinal principle in view:

The conception of mental disease is not an absolute one. There are no sharp limits between sanity and insanity. The boundary lines of both run rather deep into each other.

To illustrate the principle, I will call your attention to similar relations in diseases of the body. An individual, for instance, who is afflicted with pneumonia, be it ever so light in appearance and symptoms, will certainly be designated as sick by every one. Likewise, a person who has acquired a severe cold and running at the nose, which makes him unable to work for a certain degree. If, however, somebody has acquired a very light cold, producing only a three-times repeated attack of sneezing, probably no one would consider and declare him sick. Now, then, what shall be the verdict in a cold of medium severity?

In regard to the practically important mental disorders, a comparison with deformities of the body will be still more suitable. An individual with club-feet or with conspicuous knock-knees, will always be regarded as a cripple. By no means, however, every person with knock-knees. You will remember from Dr. Parmalee's able address, that this anatomical condition is the rule in the fair sex. To illustrate the practical value of this point I will state, that the question for instance, if such an individual should be declared as unfit for military service, or if he should be advised to submit to a surgical operation, must, before all, depend on the intensity of the deformity, and also on the formation and

general health of the whole body. There are, and will be, frequent cases in which the decision depends only on the individual opinion of the examining physician. No cast iron rule exists that can be made generally applicable in such cases.

Exactly the same condition prevails in mental aberrations and abnormalities of intellect. These indefinite limits between disease and soundness of mind have been frequently discussed in later years, and the statements which I have made will not arouse unconditional objection. Nevertheless, there are a good many who, although recognizing the existence of indefinite forms of mental equilibrium, always endeavor to find and lay out specific points, by which it shall be possible to declare with scientific exactness, if a certain abnormality of mind is a diseased condition or not. And where it is not possible at the present time, they hope for a success in solving the question in the future. It seems, however, that all these intentions are wrong, because they are in contradiction with the cardinal principles which I have given before.

Some are of the opinion that moral defects should be declared as a diseased condition, if an organic cause, a disease or abnormality of the brain, can be demonstrated, otherwise they should be declared as ordinary faults of character and not submitted to the opinion of the medical expert. This view is based upon the correct foundation that, very frequently, moral defects result from an inherited disposition, which, according to modern physiology, naturally must have its material basis in the brain, the organ of moral qualities in general. In such cases, moral defects are due, beyond any doubt, to the inherited condition of the brain; they have an organic cause. In this, however, these moral defects do not differ at all from other ordinary defects in character, indeed, from other qualities of character in general, may they be good ones or bad ones. The character as a whole, as well as in different qualities, are functions of the brain, and based on the specific condition of this organ; that means they all have an organic basis. Consequently, a defect of character in a man has just as well its organic basis as, for instance, has a prominent musical talent, or an extraordinary developed good-heartedness, which all have their cause in a specific condition of the brain. This goes to show that the organic basis cannot be used in the distinction of moral defects, or rather in the distinction of a diseased or healthy condition.

With apparently more right it has been claimed that in one case the abnormality of character was inherited—in the other acquired by education, education in the broadest sense of the word. Here we must offer the objection that the development of character is never due to one or two conditions alone, but that both always work together. In doubtful cases we must give the greater importance to inherited qualities. Even the most careful training will, even in the most favorable case,

never succeed, to induce into a cat a trace of the obedience and attachment which we find in a dog, for whose training not the least care has been taken. Likewise, the most careful education will not succeed to transform an individual with inherited moral defect, into a man of perfect character. On the other hand, careful training will bring out many qualities in an apparently indocile dog which are missed in the untrained. The influence of education, therefore, shall not be denied at least. In no case, however, can we say that a certain condition of character is solely the result of education, and another solely the result of inherited qualities.

It has been said that according to the preponderance of the one or the other moment, a defect in character should be designated as diseased or normal. In regard to this it must be admitted that a fault in character which is the result of bad education, offers more prospect for abatement or improvement than the one which is the result of inherited tendency; indeed a difference of importance and practical value.

This discrimination, however, is also of merely a relative value, not only in the sense which I have referred to before. The prospects for the improvement of a morally defective individual will be minimal where the unfavorable influences of education in an individual with good inherited qualities have been in action from early childhood up to the age of about 30 years, at which time the plasticity of the brain has decreased very materially, and where, consequently, this organ can be influenced only very little by good education. Before all, a fault in character, however it may originate, can never be something ordinary or normal. This is intimated, however, by the differentiation of ordinary defects and such which are based on a diseased condition. To speak of a "normal defect" is a *contradictio in adjecto*.

Therefore I repeat, that all the intentions to find a specific symptom of the diseased condition in these peculiarities of intellect have not a good foundation. If a certain individual should be declared as being of sound or diseased mind, depends in very many cases not on the quality, but on the quantity of the abnormality. This quantity, however, can not be expressed in numbers, otherwise it would be possible for the law to fix in all the disputed cases a certain limit for the normal, as has been done, for instance, for the size of the human body in regard to the ability for military service and the police force.

This is not possible in the estimation of soundness of mind, and the consequence is only natural that the decision must differ according to the subjective view of the observer. We can now not only understand, but we can see the necessity, that the decision must be influenced by the involved legal object. This legal object, however, does not directly concern the medical expert, but must be decided by the judge. An under-

standing between the two should be arrived at. This very point is the source of many collisions and complications, which all could be avoided, if the boundary line between sanity and insanity could be definitely fixed. For this very reason it must be demanded that the expert does not keep exactly and alone the medical side of the question in his view, but he naturally must take in consideration such points which more or less belong into other fields. Based upon this demand, however, we observe the result, that other individuals besides the medics consider themselves entitled to an opinion in such cases, namely men of law as well as the public at large. The latter, however, cannot have as much understanding of the question as the physicians, nay, they even had to deny the fundamental principle, that the conception of health and disease of mind is only a relative one, if they would avoid a contradiction with others of their fundamental principles and views. I have in mind the dualistic conception of life and the supposition of a free will. For the dualist, soul and character are considered as something independent of the materia of the body, and in no way depending on an organic basis. Nevertheless we find that lunacy is today rather generally considered as a disease of the brain-matter by the laity—or only by a few extravagant persons looked upon as the action of the devil.

For the dualist, therefore, a disease of mind must be something foreign, something from outside, affecting the moral soul, which itself is believed to be independent of the body. It is now easy to understand, if a large number of laymen, accepting this dualistic view, are looking for absolute and strict boundary lines between health and disease of mind. We find the same thing done—and logically so—by those men of law, who consider the conception of a free will as a *conditio sine qua*. The conception of guilt and punishment must be dropped, and without which no right of legal punishment can exist. This view has indeed formed the basis of all theories in legal punishment in the past, and consequently the demand for the recognition of a free will is often found as a juristic axiom. We will see later, that this is a mistake. Let us first, however, make some historical observations which may furnish a better understanding of the points in question.

All punishment, as used and practiced nowadays by the government, has primarily developed from private, personal revenge, which by and by has changed hands from the individual to the family and afterwards to the government. During the slow process of this change the primary idea of revenge has changed to the one of atonement, which conception has governed the views of law since long ago. It appears to me, that already in the most primitive form of punishment, the personal revenge, another idea leaks through. I mean the idea of a protection against the future repetition of offenses and damages from the

perpetrator. This idea of protection has more and more developed during the gradual change from personal revenge to legal punishment, and we can say it has gained the preponderance. Jurisprudence has formulated these two points in legal punishment:

1. We punish: *quia peccatum est*, because the offense has been committed.

2. We punish: *ne peccetur*, to prevent the repetition of the offense.

Absolute theories of legal punishment almost entirely neglect the second point, laying stress almost solely on the first one, *quia peccatum est*. Thereby the idea of revenge and atonement gains the preponderance in the theories of legal punishment. For such a view and theories the supposition of a free will is certainly a *conditio sine qua non*, and it is only natural that the conception of responsibility and non-responsibility had the same basis.

These views, however, can not be brought in harmony with those of modern medicine and the natural science at large, of which medicine must be considered as a branch, which have gained more and more ground since the middle of this century, and it is easy to understand that grave collisions, contradictory opinions and oppositions have resulted. It must be expected that the present time and the nearest future will find the proper solution of the problems.

For the object of presenting my views it may suffice, what I have said. I will not undertake the task, to disprove opposite opinions, the conception of dualism, and the question of a free will. My object was only to show the causes of disharmony and the necessity for a change in the nearest future. Some of the old, absolute theories of legal punishment must be abandoned, and we should more recognize the results and views of the modern natural sciences, especially the teachings of Lombroso and the Italian school in regard to criminal anthropological theories.

In legal punishment we should give more consideration to the object: *ne peccetur*, and less to *quia peccatum est*.

The solution of the problem is a task for men of law, and we will leave it for them.—Medical Compend.

The Removal of Pelvic Inflammatory Masses by the Abdomen after Bisection of the Uterus.*

By HOWARD A. KELLY, M. D.

I pointed out but recently (Johns Hopkins Hospital Bulletin, 1900, XI, 56, and Amer. Jour. Obst. 1900, XLII, August) the great advantages which accrue from the bisection of the myomatous uterus in an abdominal enucleation in certain complicated cases. I now desire to call your attention to the great value of a similar operation in certain cases of pelvic inflammatory diseases.

*Original abstract of an address delivered before The Southern Surgical and Gynecological Association, Atlanta, Ga., November 13, 1900.

In the ordinary cases of pelvic inflammatory diseases, the ovaries are innocently and only accidentally involved in the inflammatory process, and as a rule one or both can be saved, even though it is necessary to sacrifice the uterine tubes. If one ovary is saved, the uterus must also be saved, as by doing this we conserve the function of menstruation as well as the internal secretion of the ovary.

Where the ovaries are seriously involved in the disease, where they are converted into abscess sacs or into hemotomata, or where they are so densely and intimately involved with the pelvic inflammation that it is utterly useless to attempt to save them, the removal of the diseased organs should be effected together with the uterus whenever it is possible in this way: by freeing the tube and the ovary on the least adherent side first, and then after tying off the broad ligament and pushing down the bladder, and securing the uterine artery, the most difficult side is easily reached and enucleated, by cutting across the cervix and exposing the opposite uterine vessels and ligating them. The uterus is then pulled up until the round ligament is caught and divided. At this point the operation may follow one of two courses, according to the difficulties encountered: In the first place, if after dividing the uterus and pulling it up, the remaining tube and ovary can be readily enucleated by peeling them out from below upwards by working with the fingers in the lower and anterior part of the pelvis, just opened up by the detachment of the uterus, then the enucleation may be concluded by removing all the structures en masse. In the second place, if the tube and ovary on the far side are densely adherent and offer any serious difficulties in the enucleation, then I would clamp off the uterus at the cornu and remove it with one tube and ovary, and leave the more difficult side to be dissected out after emptying the pelvis, securing all the advantages of increased space and light.

It is my desire now to describe a method of enucleation through an abdominal incision which is applicable to a class of cases still more difficult than those just referred to. Let us suppose, for example a case in which there are pelvic abscesses on both sides densely adherent to all the surrounding structures, including the uterus; we will also suppose that the uterus itself is almost or quite buried in a mass of adhesions. In such a case the plan I have just described in detail is scarcely applicable, inasmuch as there is no easier side to begin on to start the enucleation, for both sides present the utmost difficulties.

Now in such a case the method of a continuous transverse enucleation does actually accord us, it is true, a great advantage over the older method of going down on both sides, for the simple reason that the enucleation of one side, the further side, is always easier in this way, even though the difficulties of the first side are just the same after either method.

If now I could devise any method by which the enucleation of both tubes and ovaries could be effected from below upwards, it is manifest that a great advantage would be gained.

The vaginal hysterectomists have thus far had a decided advantage over those of us who prefer to operate above the symphysis, in the greater facility of the enucleation of adherent structures when they are attacked in a direction from the pelvic floor upwards. I am now about to describe a method by which this decided advantage is secured and combined with the other great advantages of the abdominal route, that of increased room, and increased facilities of handling, abundant illumination, as well as the detection of various complicating conditions.

The steps of the method are these: If the uterus is buried out of view, the bladder is first separated from the rectum and the fundus found. Then if there are any large abscesses, adherent cysts, or hematomata, they are evacuated by aspiration or puncture, and the rest of the abdominal cavity is well packed off from the pelvis.

The right and left cornua uteri are each seized by a pair of museau forceps and lifted up, the uterus is now incised in the median line in an antero-posterior direction, and as the uterus is bisected, its cornua are pulled up and drawn apart. With a third pair of forceps the uterus is grasped on one side on its cut surface, as far down in the angle as possible, including the anterior and posterior walls. The museau forceps of the same side is then released and used for grasping the corresponding point on the opposite cut surface, when the remaining museau forceps is removed. In this way two forceps are in constant use at the lowest point; I commonly apply them three or four times. As the uterus is pulled up and the halves are everted, it is further bisected down into the cervix, or if the operator desires to do a pan-hysterectomy, all the way down into the vagina. The uterine canal must be followed, if necessary using a grooved director. The museau forceps are now made to grasp the uterus well down in the cervical portion, if it is to be a supra-vaginal amputation, and the cervix is bisected on one side. As soon as it is divided and the uterine and vaginal ends begin to pull apart, the under surface of the uterine end is caught with a pair of forceps and pulled up and the uterine vessels which can now be plainly seen, are clamped or tied. As the uterus is pulled still further up, the round ligament is exposed and clamped, then finally a clamp is applied between the cornu of the bisected uterus and the tubo-ovarian mass, and one-half of the uterus is removed.

The opposite half of the uterus is also taken away in the same manner. The pelvis now contains nothing but rectum and bladder, with right and left tubo-ovarian masses plastered to the sides of the pelvis, affording abundant room for investigation of their attachments

as well as for deliberate and skilful dissection; the wide exposure of the cellular area over the inferior median and anterior surface of the masses, offers the best possible avenue for beginning their detachment and enucleation.

The operator will sometimes find on completing the bisection of the uterus that he can just as well take out each tube and ovary together with its corresponding half of the uterus, reserving for the still more difficult cases, or for a most difficult side the separate enucleation of the tube and ovary after removal of the uterus.

The operation which I have just described is not recommended to a beginner in surgery; the surgeon who undertakes it must be calm and deliberate, and must bear in mind at each step the anatomical relations of the structures.

The most critical point is the bisection of the cervix and controlling the uterine vessels; if the cervix is slowly and cautiously severed with a steady traction on the uterus under perfect control there is no danger of seeing the organ suddenly tearing out with rupture of the uterine vessels and frightful hemorrhage. As the divided cervix is pulled apart, the uterine vessels are beautifully exposed and easily caught; only a clumsy operator will plunge his needle or a pair of forceps deep down into the tissues and clamp a ureter. By cutting up the cervix so as to leave a sliver on each side, the uterine vessels can be caught at a higher level than that of the division of the cervix.

If the uterus is densely adherent to the rectum all the way up to the fundus, a modification of this plan of operating may be followed; the anterior face of the uterus may be bisected and the cervix divided horizontally and the uterine vessels caught, then the rest of the uterus may be carefully divided up its posterior surface in a direction from the cervix towards the fundus. The relations to the rectum are examined as the division is made, and at any point where it seems necessary a piece of the uterine tissue may be left adherent to the bowel. After the bisection the rest of the enucleation is effected as described above.

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—Annals Gynecology and Pediatrics.